STATE OF NEVADA

Early Childhood Comprehensive Systems Strategic Plan

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September 2007
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Acknowledgements

The Nevada Early Childhood Comprehensive Systems staff would like to thank the Task Force and Advisory Members for their contributions to this Strategic Plan. Thanks to their dedication and support, there is a Strategic Plan for the children, age prenatal to five, in Nevada. Those who contributed to this Strategic Plan include:

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Introduction

"Among the most accomplished and fabled tribes of Africa, no tribe was considered to have warriors more fearsome or more intelligent than the mighty Masai. It is perhaps surprising then to learn the traditional greeting that passed between Masai warriors. 'Kasserian ingera,' one would always say to another. It means, 'and how are the children?'

It is still the traditional greeting among the Masai, acknowledging the high value that the Masai always place on their children's' well-being. Even warriors with no children of their own would always give the traditional answer. 'All the children are well.' Meaning, of course, that peace and safety prevail, that the priorities of protecting the young, the powerless are in place, that Masai society has not forgotten its reason for being, its proper functions and responsibilities. 'All the children are well' means that life is good. It means that the daily struggles of existence, even among a poor people; do not preclude proper caring for its young.

I wonder how it might affect our consciousness of our own children's' welfare if in our culture we took to greeting each other with this same daily question: 'and how are the children?' I wonder if we heard that question and passed it along to each other a dozen times a day, if it would begin to make a difference in the reality of how children are thought of or cared for in this country?

I wonder if every adult among us, parent and non-parent alike, felt an equal weight for the daily care and protection of all the children in our town, in our state, in our Country…I wonder if we could truly say without any hesitation, 'the children are well, yes, all the children are well.'

What would it be like…if the President began every press conference, every public appearance, by answering the question, 'And how are the children, Mr. President?' If every governor of every state had to answer the same question at every press conference: 'And how are the children, Governor? Are they all well?' Wouldn't it be interesting to hear their answers?" [1]

How are the children?" is a provoking and powerful question. It implies what we have all heard many times, our children are our future, for if children can develop into healthy, productive adults, our communities' futures will be well. Not only does the answer to this question point to future success, it is a barometer of our community's current state. It is the most vulnerable in our communities who first feel the effects of public policies and societal conditions. Who are more vulnerable than young children? If we truly want to know how our state is doing, we need not look to economic trends, crime statistics, and social inequalities. We simply need to ask, "How are Nevada's Children?"

[1] Rev. Dr. Patrick T. O'Neill, Senior Minister of First Unitarian Church of Wilmington, Delaware. Written in 1991 as a sermon for the First Parish in Framingham, MA.

The Plan

This plan endeavors to address this question and identify ways Nevada can answer the above question with this response, “Our children are well!” It describes a vision for a comprehensive system of services for children and families in Nevada and the means to make that vision a reality. To accomplish these goals a broad set of policies with a sustained focus on the future needs to be developed if Nevada is to change and alter significantly the long-term developmental outcomes of its children. Between birth and entry into kindergarten, all children encounter challenges for which they and their families may require some form of assistance. These challenges can range from minor health or behavioral problems to more severe developmental difficulties. To successfully address these health and developmental concerns and maximize their children's potential, families need health, education, and related developmental services that are comprehensive, of high quality, and easily accessible.

Such a system does not exist in Nevada. In most communities, the provision of accessible, sustained educational and developmental services does not begin until age five, when children enter elementary school. Although basic services are sometimes available through Medicaid and the expansion of the Nevada Check Up program, these services often do not provide adequate and appropriate developmental assessments and interventions. Similarly, while families are increasingly relying on child care services, Nevada parents state that these services are often of poor quality and difficult to find, get to, and pay for. These and other deficiencies suggest that leadership is needed at the state and local levels to advance school readiness policies that do the following:

- Enhance the capacities of Nevada's communities to improve the environments for families, social services, health care, child care and education where young children grow and develop.
- Develop a system of comprehensive, integrated, high quality, early childhood services in every community.
- Improve accountability and performance measurements to ensure that all public funds directed toward young children are coordinated and achieving desired outcomes.

State and local leadership will play a valuable role in helping the state and its communities, including parents, local policymakers, service agencies, schools, and caregivers, to work together as partners and "bridges” to start and sustain children on the developmental journey. Such bridges, *an integrated, comprehensive network of support services*, are too often missing from the lives and communities of young children and their families. As a result, families in Nevada must often navigate the difficult transitions and stresses of parenting young children with little support or guidance.

How children are prepared to begin their formal education can play a major a role in their school readiness and future success. The concept of school readiness is complex and has important ramifications for children, families and communities. Through the Early Childhood Comprehensive Systems (ECCS) initiative, families with young children in Nevada will soon have a road to follow, a map to guide them, and rest stops along the way, if they are needed.

Needs Assessment

Basic Description

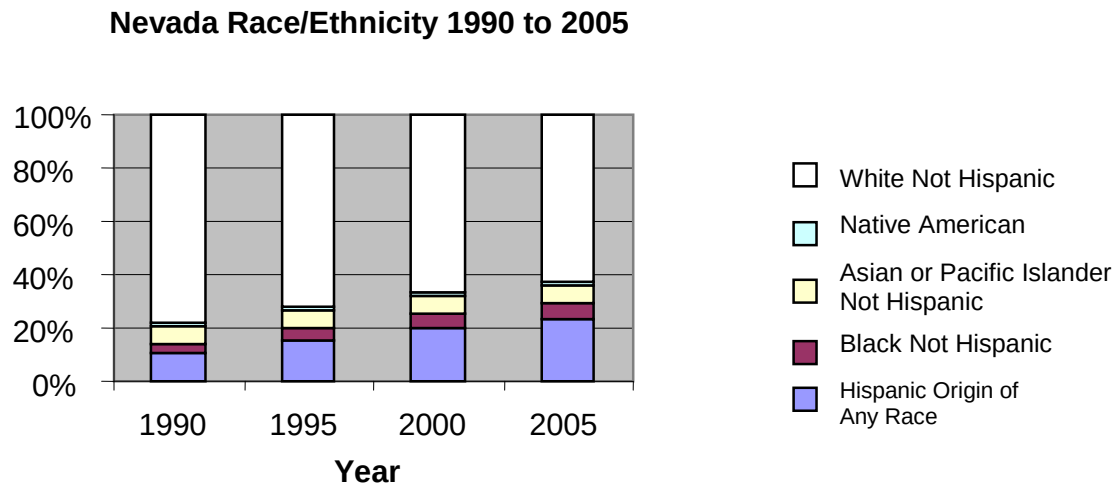
Nevada is a semi-arid, largely mountainous state with numerous valleys of primarily north-south orientation. The Sierra Nevada Mountains form a natural barrier on the west between Nevada and California. The Great Salt Lake Desert isolates eastern Nevada from the population centers of Utah. Approximately 83 percent of Nevada's land area is under the jurisdiction of the Bureau of Land Management; the remaining 17 percent is under private ownership or state and local jurisdiction.

Nevada is composed of 17 counties. Approximately 71 percent of the population resides in one county–Clark County. Only two counties in Nevada, Washoe and Clark, are urban. Two counties are designated small metropolitan areas; three counties are rural; and ten counties are frontier, i.e., no more than six residents per square mile. Nevada has 26 tribes living in the state with 23 reservations and six military bases statewide.

From 1990 to 2005, Nevada has been the fastest growing state in the nation. The population doubled from 1,315,560 in 1991 to estimated 2,623,050 in 2006[2.] Per the U.S. Census Bureau figures, Nevada has been the nation's fastest growing state for 19 straight years Las Vegas is the fastest growing metropolitan area in both Nevada and the nation. The vast majority of growth has been by immigration.

Most of the population growth is from persons moving to Nevada from other states and from outside of the Unites States. Nevada has one of the country's largest non-documented populations. According to the Pew Hispanic Center's 2005 report, Figure 1, more than 40 percent of Nevada's foreign-born residents are undocumented.[3] This increasing undocumented population manifests itself as the state's changing ethnic breakdown.

Figure 1: Race/Ethnic trends in Nevada's population 1990 to 2005.



[2] Nevada State Demographer's Office, 2006 DRAFT for Certification Estimate of Nevada's population.
[3] Pew Hispanic Center's 2005 report, http://pewhispanic.org/reports/surveys/.

The Hispanic population is the fastest growing ethnic group in Nevada (Table 1). In 2005, approximately 63 percent of Nevada's population was White not Hispanic, 23 percent of Hispanic Origin, seven percent Black not Hispanic, six percent Asian or Pacific Islander, and one percent Native American. The growth of the Hispanic population is most dramatic for those under the age of 18 years, representing 34.2 percent of the population.[4]

Table 1: Demographics of Children and Youth Ages 17 and Under in Nevada by Race/Ethnicity: 2005

Race/Ethnicity	*Number*	*Percent*
White	314,486	49.6
Hispanic (All races)	216,003	34.2
Black (African American)	53,493	8.5
Asian or Pacific Islander	39,562	6.3
Native American, Eskimo, or Aleut	8,868	1.4
ALL CHILDREN	632,412	100.0

Note: The racial/ethnic categories were provided by the state demographer. Resident population excludes group quarters.
Source: Nevada State Demographer, estimates as of October 2006.

The growth of minority populations presents continuing challenges and opportunities to the design of services that are culturally accessible and relevant to the needs of the various population groups.

[4] Nevada Kids Count Data Book, 2006

Economics Conditions

Nevada, although having low numbers of children living in poverty, is one of the worst states for children's well-being.

Before assessing the needs of young children and their families, we will first examine the conditions that may influence the community's ability to support the healthy development of young children. The need to examine these conditions was made evident through the planning process and the comments of planning participants. Many of the participants indicated that the same types of planning efforts and activities had been tried within the last fifteen to twenty years, yet the desired results are never achieved. Thus, some frustration was voiced about continuing to plan and implement the same strategies, called by differing names, repeatedly without making any progress! This led the ECCS team to the conclusion, no matter what strategies are tried, if they are implemented within the same structure, they will continue to fail to achieve the desired results. Therefore, we must take the time to examine the conditions that may have influence on the success or failure of the Early Childhood Comprehensive System.

Nevada has much strength, a thriving economy, rapid growth, recreational opportunities, and many natural resources; however, it is not known for its services and programs for children and families. Nevada is among the most geographically diverse states in the nation. It has two counties with large urban areas where high end entertainment for families is embraced and touted and adult entertainment resorts with the world's most lucrative gaming and tourist adventures imaginable. Nevada also consists of 15 lesser-populated counties with many rural communities that are relics of the old western way of life. Some communities still consider themselves as the "real wild west" frontier. For families that do not need to depend on public services, Nevada is a great place to raise children. Despite Nevada ranking among the wealthiest states with comparatively low numbers of children living in poverty, reports and assessments on the well-being of families and children suggest that very limited and inconsistent resources are being spent to meet children's needs[5].

Children's Advocacy Alliance, Nevada's Children's Report Card 2006 graded Nevada within four categories: education, health and safety, security, and teen years.[6] Within each category, national rankings established the grade given. A grade of "A" was given for a ranking of one to ten (best) and a ranking of 41 to 50 would represent a grade of "F." The 2003 report indicated that Nevada ranked as one of the top states for having the fewest children in poverty. Yet, the 2006 report card shows Nevada receiving an overall grade of "D-", and a "F" for health insurance, prenatal care, immunizations, fear of violence, money per pupil, pupil to teacher ration, high school dropouts, teen suicides, and drugs. Additionally, Nevada received "D" grades for dating violence, student achievement and teen birth rates. Thus, the evidence proves that Nevada, although having low numbers of children living in poverty, is one of the worst states for children's well-being.

[5] Children's Advocacy Alliance, Nevada's Children's Report Card 2006
http://communitylink.reviewjournal.com/servlet/lvrj_ProcServ/dbpage=cge&gid=0100901055095264229769659 6&pg=013110010510336489232406 90

[6] Children's Advocacy Alliance, Nevada's Children's Report Card 2006
http://communitylink.reviewjournal.com/servlet/lvrj_ProcServ/dbpage=cge&gid=0100901055095264229769659 6&pg=013110010510336489232406 90

Donna Coleman, the author of the 2003 Children's Advocacy Alliance, Nevada's Children's Report Card, describes the problem:

> *When states rank low in education and health care and high in drug use, they almost always share something else: children living in poverty. However, if we were to grade Nevada on children living in poverty we would get a B. This anomaly shows we are a wealthy state unwilling to spend money on our children.*

This conclusion indicates that Nevada's children and families are not a priority with Nevada policy makers and voters. Many findings point to the state's approach to funding programs, services and education for children and their families as piecemeal and under-funded rather than as a comprehensive approach to children's, family and communities needs.

A Statistical Portrait of Nevada's Children

This critique endeavors to show where Nevada stands on a few issues affecting children and families. The following data should prompt everyone who interacts with children, parents, child care providers, school districts, community organizations, and others to consider what role they can play in preparing young children for success in school and life.

There are 190,974 young children (under age 6) of whom 95,197 are infants and toddlers (under age 3) in the state of Nevada.[7] The projected greatest increase in population between the years 2005 to 2010 is among the birth to four year age group. (See table 2 below.)

Table 2: Projected Demographic Change of Children and Youth in Nevada by Age: 2005 to 2010[8]

Age Groups	***2005***	***2010***	***Percent Change***
0-4 years	178,729	224,435	25.6
5-14 years	347,218	414,875	19.5
15-19 years	178,136	214,722	20.5
ALL CHILDREN	704,083	854,032	21.3

Note: Resident population excludes group quarters.
Source: Nevada State Demographer, estimates as of October 2006.

Kids Count and Nevada Kids Count, has Nevada ranked 33rd among the 50 states on the overall well-being of children. Nevada has never risen above 30th despite higher rankings in median family income and having relatively low child poverty. The Annie E.

[7] Nevada Early Childhood Profile, National Center for Children in Poverty, Columbia University, May 1, 2007.
[8] Nevada Kids Count Data Book 2007, http://kidscount.unlv.edu/2007/kc_wholedatabook_2007.pdf

Casey foundation tracks the status of children by using a method that evaluates the benchmarks of child well-being. Below are highlights from this document (note that the scale is 1-50, 50 being the "worst"):[9]

- Nevada ranks 22nd (8.0 percent) in the percent of low birth weight babies for 2004; this ranking has improved from 25th in 1996.
- Nevada ranks 23rd in the infant mortality rate (6.4 percent deaths per 1,000 live births) for 2001. This ranking has decreased from 13th in 1996.
- Nevada ranks 20th in the child death rate (21 deaths per 1000,000 children ages 1-14). This ranking has improved from 34th in 1996.
- Nevada ranks 49th with only 71 percent of 2-year-olds who were immunized in 2005.
- Nevada ranks 46th with 16 percent of children age 17 and below without health insurance and for the 0-5 year old population. This represents 18 percent of the children.
- Nevada ranks 16th with 15 percent of children under age 18 who live in families with incomes below the U.S. poverty threshold; it was ranked 14th in 1996.
- Nevada ranks 31st (32 percent) in the percent of families headed by a single parent; it was 29 percent in 1996.
- Per capita income in Nevada was $30,529 in 2000, raking 14th among the states, 2.9 percent higher that the U.S. average, yet it ranks near the bottom when it comes to funding education and social services and programs for families. [10]
- Children with special needs living in Nevada represent about 11 percent of the total child population aged 0-17 (approximately 533,000). Most of the children with special needs live in urban centers: 66 percent in the Las Vegas area and 22 percent in the Reno/Carson City area.
- In Nevada children 0 to 5 years of age with special needs, represent 6.1 percent compared to the national average of 7.8 percent for that age group.
- In Nevada, the percent of Children with Special Health Care Needs whose condition caused financial problems for the family is at 22 percent verses 20.9 percent nationally.[11]
- In Nevada, the percent of Children with Special Health Care Needs whose families spend 11 or more hours per week providing or coordinating care is at 17.2 percent verses 13.5 percent nationally.[12]
- In Nevada, the percent of Children with Special Health Care Needs without a usual source of care (or who rely on the emergency room) is at 13.2 percent verses 9.3 percent.[13]

[9] KIDS COUNT overall rank: Number: 2004/2005, http://www.kidscount.org/sld/compare_results.jsp?i=1000
[10] Southern NV Community Assessment 2003, http://www.nevadacf.org/CommunityAssessment.pdf
[11] The National Survey of Children with Special Health Care Needs Chartbook 2001, http://mchb.hrsa.gov/chscn/state_data/nv.htm
[12] Ibid.
[13] Ibid.

- In Nevada, the percent of Children with Special Health Care Needs needing specialty care who had a difficulty getting a referral is at 29.5 percent verses 21.9 percent.[14]

The needs are many. With the exploding populations and diversity in Nevada's neighborhoods, disparities are brought to the forefront. Nevada must break new ground in education policies, social services, health services, and family well-being issues. This may include the development of a model that includes some level of consolidation of state programs, as well as the development of a strong leadership body. This leadership body should be one with both state agency leadership and with local leadership that can serve as an advocacy base to coordinate services at all levels and promote school readiness for all children being paramount for the future economic success of the state of Nevada.

Nevada's Needs As They Relate To School Readiness

What is School Readiness?

"School Readiness" is heard more and more often when talking about Early Childhood issues – but what is it exactly? School readiness is the concept that all children should arrive at school ready for the first day. The term "ready" suggests a distinct set of skills that facilitate children's ability to succeed in school, such as having motor skills to hold a writing utensil, self-control to sit quietly during circle time, or language skills to be able to communicate their wants and needs. But, it is not just children who need to arrive at school "ready." Communities must be "ready" to support their young children; families must be "ready" to support their children's growth and development, and schools need to be "ready" to foster each individual child's learning.

Factors affecting our youngest Nevadans entering school not ready to learn

Studies have shown that factors associated most consistently with children's cognitive and/or social-emotional preparedness for school are socioeconomic status (which often interacts with race or ethnicity).

Findings:

- 8.3 percent of babies born in Nevada during 2006 are low-birthweight babies (LBW) for the year;[15]
- 29.5 percent were born to unmarried parents; [16]
- Nevada's average teen birth rate for 2003-2005 was 46.6 per 1,000 females ages 15 to 19;[17]
- In 2004, an estimated 15.3 percent of children under age 18 in Nevada lived in poverty. *(Poverty=families with incomes below the U.S. poverty threshold);*[18]
- In 2005, only 39 percent of Nevada's children age 3-5 years were enrolled in nursery school, preschool or kindergarten, compared to 57 percent nationwide;[19]

[14] The National Survey of Children with Special Health Care Needs Chartbook 2001, http://mchb.hrsa.gov/chscn/state_data/nv.htm.
[15] Title V Block Grant Application, State: NV, Application Year: 2008, http://health2k.state.nv.us/docs/MCHApplication2008.pdf
[16] Nevada Kids Count Data Book 2007, http://kidscount.unlv.edu/2007/kc_wholedatabook_2007.pdf
[17] Ibid
[18] Ibid

- In 2005, 29 percent of Nevada's children spoke a language other than English at home, compared to only 20 percent nationwide;
- State-funded Pre-Kindergarten for 2005-2006 served/enrolled 1,125 children with a state expenditure of $3,032,172.[20]

Table 3: Comparison of the Number of Child-Care Licenses in Nevada by Type of Facility: January 1 - June 30, 2000 and 2004[21]

Type of Facility	Licenses 2000	Licenses 2004
Family home	590	541
Child-care center	352	352
Accommodation facility	35	37
Group home	33	25
Preschool	38	41
On-site child-care facility	7	9
Nursery for infants and toddlers	5	6
Child-care institution	4	5
Special needs facility	1	2
TOTAL	1,065	1018
TOTAL SPACES	**40,480**	**45,559**

[19] The 2007 KIDS COUNT Data Book, http://www.aecf.org/Home/MajorInitiatives/KIDSCOUNT.aspx
[20] Nevada Early Childhood Education (ECE) Program, 2005-06, Evaluation Report
[21] Nevada Department of Human Resources, Division of Child & Family Services, Bureau of Services for Child Care, Statewide Child *Teacher* Care Licensing Report, 2001 and 2005.

Factors affecting Child Care in Nevada

Research shows that the more stringent standards are in child care programs, the higher their quality is.

> *Throughout the United States, many children are failing to reach their full potential in school. But driven in part by what we have learned about early childhood development, the academic, business (The Business Roundtable, 2003) and policy communities now recognize that high-quality preschool programs are an important way to rectify this situation. And, based on what the research has shown thus far, it appears that teacher preparation at the four-year college degree level is the best way to achieve such quality. We do need, however, to learn more about effective alternative pathways to teacher preparation, particularly to ensure linguistic and cultural diversity in preschool programs.*[22]

In a 2004 analysis of the licensing regulations of all 50 states, Nevada is seen as having lower than average standards on a variety of measures that relate directly to the quality of child care. A number of characteristics of child care that are amenable to regulation and which have a significant impact on the expected outcomes for young children are low child-to-staff ratios, small group staff educated in early childhood education and low staff turnover rates. As children enter elementary school, the children who have been in high quality child care situations will have higher academic skills, greater language development, more positive social interactions with peers and reduced behavior problems in school. [23]

Quality of child care – Lower child-to-staff ratios and smaller group sizes are associated with improved quality in child care centers.

Early childhood training requirements for teachers – Education levels (the number of years of schooling) and specific training in child care related fields are related to quality of program and both pre-service and in-service training have a positive impact on the quality of services.

> *For those who develop and implement early care and education programs, the most important aspect of their job is ensuring that young children consistently encounter teachers who are sensitive and able to create positive learning environments. Teachers of young children are increasingly called upon to have more versatility in pre-k classrooms, and their performance and actions in the classroom is an undeniable link to children's development.*
>
> *Our objective is that all pre-kindergarteners, not just a fortunate few, have access and exposure to the best teachers who are going to prepare them academically and socially, thus requiring pre-k teachers to have bachelor's degrees in specialized training in early childhood development is a*

[22] *Early Education Quality: Higher Qualifications for Better Learning Environments - A Review of the Literature,* Marcy Whitebook, PhD, Center For The Study Of Child Care Employment, Institute of Industrial Relations, University of California, Berkeley, 2003

[23] NICHD Early Child Care Research Network. (2002). Child-care structure, process, outcome: Direct and indirect effects of child-care quality on young children's development. Psychological Science, 13.

> *necessity. The research in this review firmly anchors that point. These are the teachers who are best equipped to lay the groundwork for an optimistic and rewarding experience in pre-kindergarten and beyond.*[24]

Compensation and staff turnover – High turnover rates mean children do not have consistent and reliable caregivers with whom to bond, which leads to lower academic skills, less language development, fewer social skills and behavior problems when these children enter elementary school. Child care facilities in Nevada have high teacher/staff turnover and pay teachers less than what their counter parts in the public education system earn. Benefits for child care providers are also rare, especially in private programs. A study by Eva Essa (2002), Professor of Human Development and Family Studies at the University of Nevada, Reno, found that child care professionals earn approximately half of what comparably educated public school teachers earn and that only a little over half of them receive health insurance.[25] Essa also found that teacher turnover is approximately 45 percent. Turnover is a critical measuring stick of quality child care because children do better when they become securely attached to consistent, long-term caregivers/teachers.[26] Nevada's turnover rate for child care teachers is higher than the national average estimated at 30 to 40 percent.

Early childhood and administrative training requirements for directors – In Nevada a director only needs to obtain 12 college credits in the field of Early Childhood Education (ECE). The performance of the program director, particularly as it relates to providing leadership in program functioning at the administrative level and providing high quality supervision and feedback, will predict program quality.[27]

Safe and sanitary design and the maintenance of the physical environment, and hygienic practices – Safe and hygienic facilities and practices are one of the most important types of protections state standards need to support, i.e., requiring hand washing in the reduction of the spread of infectious diseases in child care facilities.

Relationships & child-initiated activities - Continuity of a child's relationships with adults, emphasis on child-initiated activities, child participation in representational play, and positive relationships between parents and staff are consistently associated with positive outcomes for children.

Cost vs. quality - The cost of child care is high, regardless of its quality. However, high quality programs are clearly more expensive and include higher compensation for employees compared to low quality programs. On the other hand, poor quality programs have tremendous hidden costs regarding what is not adequately provided for children in terms of child development. Overall, good quality child care has positive effects and poor child care has negative effects on children and society.[28]

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[24] Whitebook, M,. (September 23, 2003) Bachelor's Degrees Are Best: Higher Qualifications for Pre-Kindergarten Teachers Lead to Better Learning Environments for Children.

[25] Essa, E. L. (2002). *Who cares for Nevada's children? The Nevada child care work force study.* Reno, NV: University of Nevada, Reno.

[26] Whitebook, M., Howes, C., & Phillips, D. (1990). Who cares? Child care teachers and the quality of care in America: Final report of the National Child Care Staffing Study. Oakland, CA: Child Care Employee Project

[27] Whitebook, M,. (September 23, 2003) Bachelor's Degrees Are Best: Higher Qualifications for Pre-Kindergarten Teachers Lead to Better Learning Environments for Children.

[28] Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development,.* Washington, DC: National Academy Press.

Licensing Standards - There are four different Child Care Licensing Agencies in Nevada. They are Nevada Bureau of Services for Child Care Licensing, Washoe County Licensing, Clark County Licensing, and City of Las Vegas Licensing. All licensing entities must meet or exceed the state's requirements. Each of the four separate entities has a somewhat different set of requirements.

Findings:[29]

- High ratios and no group size requirements in licensing make poor working environments for staff and poor learning environments for children.
- Caregivers are not required to have formal education or early childhood education or child development coursework in order to work in a child care facility.
- Wages for child care providers are inadequate, with average earnings of less than $20,000 per year.
- Staff turnover rates are at 45 percent, the highest of any profession in Nevada and one of highest in the nation.
- Wrap-around child care for Kindergarten, off-track and children with special needs is inadequate to meet the need.
- There is not enough infant/toddler care to meet the needs of families.
- There are limited child care options in rural areas of the state, where families may be forced to use unlicensed child care.
- Nevada ranks 47th in the nation, for student-teacher ratios for pre-kindergarten through 12th grade education.
- Only 20 to 23 percent of Nevada's fourth grade students scored at or above adequate reading and math levels, compared to 30 to 27 percent nationwide.
- Nevada Head Start program for the 2005-2006 school year throughout served the following:[30]
  - 3,896 children received services in regional and tribal Head Start programs.
  - 12.3 percent (474) of enrolled children had a disability or special need.
  - 46 percent (1,804) of Nevada's Head Start children speak a language other than English in the home.
  - More than 52 percent of families served were two parent families.
  - 57 percent of parents had not graduated from high school.
  - 3 percent of families served were homeless at some point during the year.
  - 86 percent of families participated in goal setting.

[29] A Comparison Study of Nevada Child Care Regulations and the National Health and Safety Standards for Child Care Programs, University of Nevada Cooperative Extension, Human Development and Family Studies, Reno, NV 89557, August, 2004.

[30] Data source: 2005-2006 Nevada Head Start Program Information Report

- 15 percent of staff are current or former Head Start Parents.
- 51 percent of Head Start teachers had a higher education degree in Early Childhood.
- Number of recipient families – 3,537
- Total spending: Federal spending - $24,215,081; State spending – None
- Spending per recipient: Federal spending per slot $8,792 per year

Medical Home and Health Insurance

The health care system plays a central role in promoting optimal child health and development and a contributing factor to school readiness. It is the one system that nearly all families come in contact in a child's first five years of life and can intervene even before a child enters school. The health care system can help solidify a child's trajectory for academic success by assuring that infants are born healthy, that parents receive child development information and support, and that children meet their optimum developmental potential. Health care services that support a child's healthy development should begin as early in pregnancy as possible and continue throughout a child's first five years of life. [31]

Access to health care services remains a fundamental problem for many children and their families in Nevada and throughout the United States. There are groups of children and youth who are not receiving recommended preventive health services, such as health screenings and immunizations. The quality of care that children receive differs widely according to insurance type and economic status. Several factors influence access to care, including having a regular source of health care (provider) and health insurance. Having a regular health provider is associated with greater continuity of care, which is of essential importance to achieving optimal child health and school readiness.

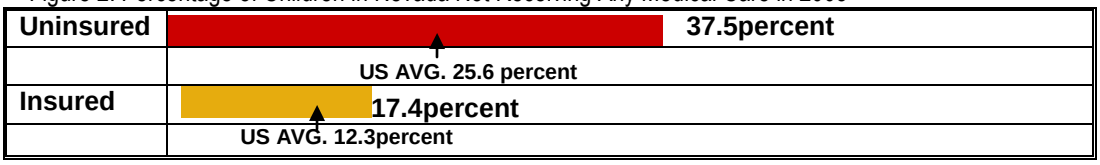
Nevada residents claim that along with educational issues, health concerns pose the strongest challenges to Nevada residents. The areas of most concern are oral/dental health care, mental health services, and access to primary care services.[32] Poor oral health and a severe misdistribution of dentists are persistent problems in Nevada. Residents ranked lack of dental health as one of the top ten community concerns.

Insured Vs. Uninsured Medical Care in Nevada

Many Nevadans worry about their mental and physical health care needs. Some of the fear and problems families are concerned about in Nevada are:

- The ability to afford medical care, including dental care– this problem has reached crisis levels for a large number of Nevadans. Nevada is second in the nation in the percentage of children without health insurance who don't get seen by a doctor (Figure 2).[33]
- Uninsured children in Nevada are far more likely than their insured counterparts to not receive any medical attention, not have a personal doctor and not receive needed medical attention (Figure 3) [34].

Figure 2: Percentage of Children in Nevada Not Receiving Any Medical Care in 2003



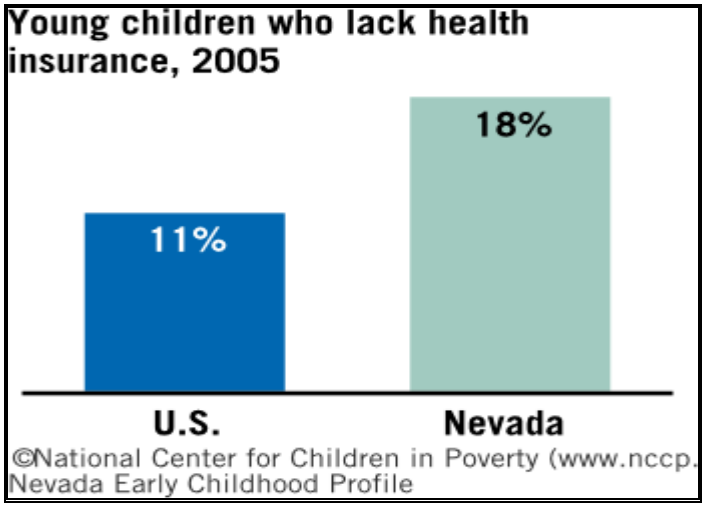
[31] SECPTAN (State Early Childhood Technical Assistance Network), 2003
[32] Southern Nevada Community Assessment 2003, United Way of Southern Nevada/Nevada Community Foundation, http://www.nevadacf.org/CommunityAssessment.pdf
[33] See The State of Kids' Coverage
[34] See Going Without: America's Uninsured Children

Figure 3: Percentage of Children in Nevada Not Receiving Needed Medical Care in 2003

Uninsured	10.9percent
	US AVG. 6.2percent
Insured	0.9percent
	US AVG. 0.65percent

The percent of uninsured has been consistently higher than the nation average for 15 years.

Figure 4: Young Children Who Lack Health Insurance[35]



- 108,639, or 18 percent, of the state's children are uninsured, based on 2002 to 2003 data. That is second only to Texas, where 21.2 percent of the children have no health coverage.
- Nevada ranks last in the nation in the amount of uninsured children whose families reported that they do not have a personal doctor or nurse [36]

Figure 5: Percentage of Children in Nevada Children without a Personal Doctor in 2003

Uninsured	52.5percent
	US AVG. 35.0percent
Insured	22.1percent
	US AVG. 13.5percent

Insurance, Hospitals, and the Rural Economy

Families' access to quality health care is related to the economy of the community. The health care sector is often one of the major employers and source of economy for the small town, and without it, the towns feel like they would struggle to maintain a viable economic base. It is difficult, however, for hospitals and clinics to maintain a profitable margin and to supply the economic base.

[35] State data calculated from the Annual Social and Economic Supplement (the March supplement) of the Current Population Survey from 2004, 2005 and 2006, representing information from calendar years 2003, 2004, and 2005. National Center for Children in Poverty averaged three years of data because of small samples sixes in less populated states. The national data was calculated from the 2006 data, representing information from the previous calendar year.

[36] See The State of Kids' Coverage.

In addition, many counties in Nevada do not have a hospital within their boundaries.

> *In rural Nevada the problems of adverse selection and moral hazard that beset health care in general, as well as the inefficiencies associated with government control of health care facilities, are amplified in many ways. The relative isolation of communities, the state-granted-monopoly status of local hospitals through Certificate of Need laws, and the apparent disconnect between policymakers and the rural residents who are affected by their decisions all contribute. In addition, there are a number of uniquely rural problems that arise. Public ownership of hospitals leads to decisions being made by non-medically trained governing boards, rather than hospital administrators. Also, recruitment and retention of physicians remains a problem, with the additional problem of loyalty to long-standing local doctors impeding reforms.*
>
> *While rural hospitals continue to face greater financial insecurity than do urban hospitals, there appear to be some reasons for optimism regarding the future of rural health care. The advance of telehealth technology, along with restructuring of telehealth regulations and innovative uses for the technology, holds great promise. As local administrators are granted more autonomy to match resources with needs under a market structure, efficiencies should increase at rural hospitals, allowing existing resources to be better utilized, thus improving health outcomes.*[37]

Health Care Shortages

Nevada suffers greatly from an acute shortage of practically every category of healthcare professional, i.e., physicians, dentists, nurses, physical therapists, pharmacists, audiologists, dermatologists and speech pathologists. The present and anticipated needs of Nevada cannot be met by graduates from existing training programs within the state. Thus, leaving Nevada vulnerable at a time when the state's population is growing much more quickly than most. The latest data reported by the Agency for Healthcare Research Quality ranks Nevada near the bottom in vital public health measures such as prenatal care, immunizations, and mental health because of these shortages.[38]

> *Nevada ranks among the lowest states for the number of health care professionals per 100,000 residents. With regard to nurses, the largest group of health care professionals in 2000, Nevada ranked 50th among states in the number of registered nurses (RNs) per 100,000 residents. Nevada has approximately 514.4 RNs per 100,000 residents, which is significantly lower than the national average of 780.2.1 Also in 2000, Nevada ranked 47th among states in the number of nurse practitioners (NPs) per 100,000 residents. Nevada has approximately 15.2 NPs per 100,000 residents, which is significantly lower than the National Average of 33.7. The 2005 Statewide Survey of Licensed Registered Nurses in Nevada estimated the state has 548 RNs per 100,000 population. This figure represents an improvement over the data reported for 2000.*

[37] Nevada Policy Research Institute, Analysis, *Health Care In Crisis: The Plight Of Rural Nevada Hospitals And Clinics,* C. Fawson, Ph.D.,J. Kidda, Department Of Economics, Utah State University, July 2002.

[38] University of Nevada School of Medicine, Health Science Center, *How Will Nevadans Benefit from the Health Sciences Center?* 2003, http://www.unr.edu/med/news/HSC.asp.

The physician-to-population ratio in Nevada ranks the state 47th in the nation with 172 physicians per 100,000 residents. The national median is 222 physicians per 100,000 residents. In 2003, the national average for physician generalists was 31 per 100,000 residents, while the average in Nevada was 23. Additionally, Nevada had 154 physician specialists per 100,000 residents, well below the national average of 220.[39]

One major problem with the quality of health care in rural areas is the shortage of health care professionals. Table 4 below indicates the rural and frontier counties, excluding Clark County, Washoe County and Carson City, which have medical, dental and mental health shortages.[40]

Table 4 – Single-County Health Professional Shortage Areas, (HPSAs), Medical Underserved Areas, (MUA), Dental Underserved Areas, (DUA) and Mental Health in Rural and Frontier Nevada by County – 2006

COUNTY	Medical		Dental		Mental Health
	Health Professional Shortage Areas	Dental Underserved Areas	Health Professional Shortage Areas	Dental Underserved Areas	Health Professional Shortage Areas
Churchill County	No	No	No	Yes	Yes
Douglas County	No	No	No	No	No
Elko County	No	No	Yes	No	Yes
Esmeralda County	Yes	Yes	Yes	Yes	Yes
Eureka County	Yes	Yes	Yes	Yes	Yes
Humboldt County	Yes	No	No	No	Yes
Lander County	Yes	Yes	Yes	Yes	Yes
Lincoln County	Yes	Yes	Yes	Yes	Yes
Lyon County	Yes	Yes	Yes	Yes	Yes
Mineral County	Yes	No	Yes	Yes	Yes
Nye County	Yes	No	Yes	Yes	Yes
Pershing County	Yes	No	Yes	Yes	Yes
Storey County	Yes	Yes	Yes	Yes	Yes
White Pine County	No	No	Yes	Yes	Yes
RURAL AND FRONTIER TOTAL	**10**	**6**	**11**	**11**	**13**

Sources: Bureau of Health Professions (2006) and Nevada Office of Rural Health (2006)

[39] Nevada Legislative Counsel Bureau, *Research Brief on Shortage of Health Care Workers*, M. D. Lyons, July 2006

[40] University of Nevada School of Medicine Nevada Office of Rural Health, *Nevada Rural and Frontier Health Data Book - 2007 Edition,* J. Packham, PhD and T. Griswold, MS, January 2007, p. 77.

Fifteen of Nevada's seventeen counties have been designated medical shortage areas or with a partial county (See figure 6). [41]

Figure 6: Primary Medical Care Health professionals Shortage Areas in Nevada - 2006

From the data presented, it is clear that Nevada has numerous issues related to access to quality medical care as a whole and especially for children. In addressing some of these issues, the Nevada State Health Division is committed to providing medically underserved communities with access to quality, affordable health care. One such way is through the J-1 Visa Waiver Program. The J -1 Visa Waiver Program gives the state authority to review and support requests from foreign medical graduates for a J-1 visa waiver of the J-1 visa. In exchange for the state supporting a J-1 physician, the physician agrees to provide medical care to medically underserved people in that state for a minimum period of three years. By federal statute up to 30 waivers may be recommend each Federal Fiscal Year (FFY) in Nevada.

Senator Harry Reid in a web announcement August 2007 addressed the health care workforce issue[42]:

> As Nevada continues to grow, so do our health care needs. On February 14, 2007, I introduced legislation with Senator Bill Nelson (D-FL) to help ensure that communities across our state have the doctors they need and the quality care they deserve. Our bill, the Resident Physician Shortage Reduction Act, would expand the number of Medicare-supported

[41] University of Nevada School of Medicine Nevada Office of Rural Health, *Nevada Rural and Frontier Health Data Book - 2007 Edition,* J. Packham, PhD and T. Griswold, MS, January 2007, p. 78.
[42] United States Senator for Nevada, Harry Reid web site: http://reid.senate.gov/issues/publichealth.cfm, August 2007.

physician residency training positions in states like Nevada that are facing significant shortages of resident physicians. Under current law, there are caps on the number of those positions. There are no exceptions to the permanent caps, and most importantly for Nevada, no adjustments are made for population growth. Our bill will allow these caps to be raised and thus allow more physicians to train in Nevada, thereby ensuring that more will stay in the state to practice.

Because Nevada is facing a nursing shortage, I will also continue to support the comprehensive Title VIII nursing education and workforce programs. These Title VIII programs merit funding because they help to encourage bright students to join the nursing profession, keep the current workforce strong, and open doors to advanced education. We also need to ensure that working conditions, such as needlestick laws, staffing ratios, and mandatory overtime rules, support our nurses' desire to provide the highest quality care possible.

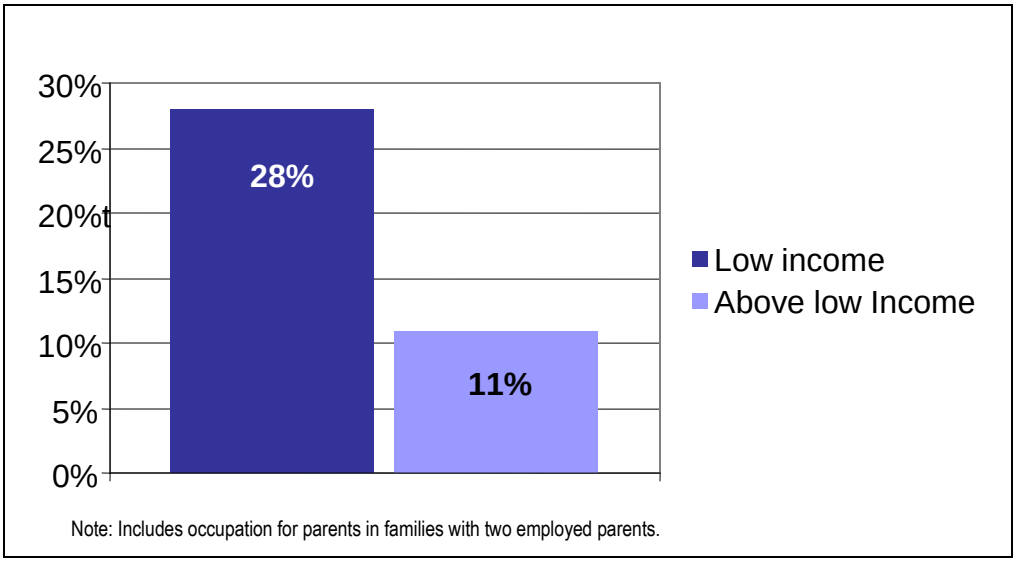
Factors Affecting Families Well Being

Nevada has many challenges and problems concerning children, families and the public and private service programs dedicated to helping young children and their families. To better understand these concerns a cultural and economic picture of Nevada is required.

Nevada has been for many years dependent on a single industry, which is tourism and gambling. It has become and is proud of being the premier entertainment and adult destination in the country. Because of Nevada's decision to embrace a tourist economy, approximately 60 percent of all workers statewide are in the service or retail trades. The five biggest issues facing Nevada's families and communities are economic issues, health (including oral health and mental health), education, services to families, and environmental issues. Racial and ethnic minority groups and women are disproportionately affected in virtually every area. Many families do not have conventional family structures with almost one-third of all local families with children being headed by single parents.

Nevada's economy provides jobs for hundreds of thousands of people, but its dependence on a service economy, tourism and gambling, relegates about a third of the state's residents to earning an income below a living wage. Often both members of a couple are required to work to make a living wage. The 24-hour economy of Nevada, particularly Las Vegas and Reno, often forces spouses to work different shifts. As a result, many juggle child care responsibilities and supervision of their children. Figure 7 shows that low-income parents who work are more likely to be employed in service occupations. Workers in service occupations are not only likely to have lower earnings and fewer opportunities for full-time employment, but they are also less likely to receive benefits such as health insurance, paid vacation, or holidays.[43]

Figure 7: Working parents employed in service occupations, by income level, 2005



©National Center for Children in Poverty, Most Low-Income Parents Are Employed

[43] Nelson, J. (1994). Work and benefits: The multiple problems of service sector employment. *Social Problems, 41*(2), pp. 240-256.

Nevada's tax structure has a direct impact on the extent to which public agencies are able to address the pressing social and health needs of the state's less fortunate residents. With limited tax revenues and an explosive demographic growth, public expenditures are curtailed, and most important, societal needs are under funded. Various assessments suggest that Nevada faces serious challenges in its efforts to meet the needs of families and their children in all communities in Nevada.

In addition to the tremendous overall population growth in Nevada, one significant demographic trend has been the state's increasing racial and ethnic diversity. The number of Hispanic, Asian, and African American residents has grown faster than the overall growth rate. The percentage of non-US citizens and non-English speakers has increased as well. This demographic change is challenging public and private institutions to develop cultural sensitivity in the delivery of services. Navigating complex public systems can become impossible for some families needing assistance.

Some examples include:

- Mental health services for children are seriously underfunded, impeding progress on critical issues such as education, homelessness, and domestic violence.
- Child protective services are under great strain with a rising number of investigations and increasing caseloads for the state's social workers.
- Many public service providers find they are ill equipped to provide culturally appropriate services in Spanish to the state's burgeoning Hispanic population.
- Agencies are struggling to keep up with the increased demand for supportive services to families in virtually all areas, and lack of service coordination often constitutes a great barrier to access.

Access to quality parenting education

Parenting plays an important role toward young children becoming successful learners. This occurs when young children's needs are met with warmth, structure, and routines. Feelings can be expressed freely. And, children are assisted with problem-solving. However, parenting is not easy. Raising young children is sometimes joyful, but it is often challenging, with constant on-the-spot decisions about what to say and do. When parents are stressed about finding a home, meeting public assistance requirements, obtaining health care, or feeling isolated and lonely, parenting is that much harder.

The family represents a critical context for children's development. Therefore, providing information and support to parents is essential to ensuring that children flourish. The overarching goal of the Early Childhood Comprehensive Systems Initiative is focused on parenting programs and services that provide parents with the tools and resources to meet their children's needs. Many Nevada children have parents and caregivers who lack knowledge of early childhood development and parenting techniques and skills. They also lack knowledge about when, where, and how to seek supportive services their children may need.

> *If family prosperity, in all meanings of the word, is to occur, public programs and private efforts must inspire new visions of family empowerment and full participation in citizenship. Such efforts must furnish appropriate means for establishing stable family life, developing parenting skills, involvement in their own and children's education,*

community participation, successful employment, support for nurturing other family members (e.g., elders), and a sense of control and self-direction.

Examination of disadvantaged families in Nevada leads to the conclusion that poverty underlies most problems, and that the root cause of most poverty is attributable to jobs that do not offer a livable wage and inadequate education and preparation, and family functioning. ...it is unrealistic to think that jobs that do not provide a livable wage or insufficient public support (or inadequate minimum wage) will create prosperity for Nevada families. Although welfare reform of a decade ago was an opportunity for the state to set policy and fund goals which could empower families, there is now a larger and more troubling need for adequate policy and funding to address the plight of the working poor.

Constructive, courageous, and informed public policy decisions will be required to move disadvantaged families toward empowerment and self-sufficiency.[. . .] Nevada families are experiencing many of the requisite changes to improve our state in the future. New families with ambition, optimism, and a belief in the future promise the energy and potential for positive change. While there are many daunting challenges, there are also promising signs that augur great possibilities for tomorrow. [44]

On the bright side Nevada has many systems in place such as:

- The Family Resource Center network and Family 2 Family, (F2F), programs both centralized services to make them more assessable to low-income families. Nevada has twenty-two Family Resource Centers/F2F. They are funded with state general funds and offer parenting services and education. The major hospitals, health clinics, universities and colleges also offer parenting education and services to families with children in the larger urban areas. Families in the rural areas do not have as many state and non-profit services as the urban areas, but the Nevada Cooperative Extension Offices offer families training and education events that are culturally appropriate, entertaining, and largely attended along with a newsletter, "Little Lives."
- Nevada Parent Information and Resource Center (PIRC) program is a discretionary grant program funded by the US Department of Education, Office of Innovation and Improvement.[45] In 2006 PIRCs were awarded to serve statewide needs. PIRCs now provide both regional and statewide services and disseminate information to parents on a statewide basis. The Parent Information and Resource Centers (PIRCs) help implement successful and effective parental involvement policies, programs, and activities that lead to improvements in student academic achievement and that strengthen partnerships among parents, teachers, principals, administrators, and other school personnel in meeting the education needs of children. PIRC's goals are:
    - To provide all families the services and support they need to become active participants in their child's education and support learning at home.

[44] Marriage and Family Life in Nevada, http://www.unlv.edu/centers/cdclv/healthnv/family.html
[45] Parent Information and Resource Center (PIRC) program, http://www.nationalpirc.org/directory/NV.html

- To strengthen partnerships parents and their child's school.
- To support pre-kindergarten parents services and support.
- To coordinate parent involvement programs and services statewide**.**

Parent Information and Resource Center (PIRC) program's Early Childhood Model includes the following Pre-K programs:

- Apple Seeds – a home-based, bilingual parent education program. Family advocates meet with a participating family weekly or bi-weekly in their home to address specific parenting needs over a period of three to eleven sessions.
- Virtual Pre-K – a statewide effort to disseminate information regarding developmentally appropriate activities, based on Nevada Pre-K standards that parents can do at home with their children. Bilingual "recipe" cards, videos and DVD's will be provided in a kit that families can check-out from their local library, daycare facility or community center.
- Classroom on Wheels Adult Learning Facility (CALF) Van – a mobile classroom that provides families trainings and resources on child development, behavior management, appropriate expectations, and family literacy.

The Nevada State PIRC will use a variety of venues to engage parents, including direct service to parents through workshops, train the trainer workshops for schools and parents, a Statewide Parent Involvement Summit and outreach at targeted events such as the Nevada State PTA Conference.[46]

- The State Infrastructure Grant at Children's Behavior Health Services within the Division of Children and Family Services is underway to create a more family-centered system for the delivery of children's mental health services through the state.

[46] National PIRC Coordination Center, http://www.nationalpirc.org/directory/NV.html

Nevada State Health Division, MCH Title V

An internal scan of the Nevada State Health Division, MCH, Title V program provides a snapshot of the status of children and strategies currently in place that address the five component areas of the ECCS Initiative as they relate to Nevada's children and their families.[47] Nevada's Title V, Maternal and Child Health Program is administered through the Bureau of Family Health Services, (BFHS), Nevada State Health Division, Department of Health and Human Services. Programs under MCH include: the Children with Special Health Care Needs Program (including newborn screening, newborn hearing screening, specialty nutrition and the Nevada Birth Outcomes Monitoring System (formerly Birth Defects Registry); the MCH Campaign, (a multi-faceted consulting initiative and information and referral line which encourages early entry into prenatal care and a Medical Home for children), Perinatal Substance Abuse Prevention; the Child and Adolescent Program (including Teen Pregnancy Prevention, Early Childhood Systems Development, and Middle Childhood systems development); Oral Health; Primary Care Development Center; WIC; and Injury and Rape Prevention.

MCH, Title V programs are administrated through direct health care services, enabling services, population-based services and infrastructure building services. According to the Maternal Child Health Bureau (Nevada Title V Snapshot 2008), the total Federal-State Partnership budget is $ 3,364,813.[48] Individuals served by the Nevada State Health Division, MCH, Title V Program for reporting year 2006 totaled 85,097.

- 7,038 Pregnant Women
- 38,479 Infants < 1 year old
- 23,532 Children 1 to 22 years old
- 3,169 CSHCN
- 12,593 Others

The Bureau of Family Health Services works very closely with four of the Health Division bureaus: Bureau of Community Health (BCH), Bureau of Early Intervention Services (BEIS), Bureau of Licensure & Certification (BLC), and Bureau of Health Planning & Statistics (BHP&S). It provides funding for BCH community health nursing and partners with BCH on chronic disease initiatives. The Center for Health Data and Research in the BHP&S works with the State Systems Development Initiative (SSDI) grant and produces the data for the MCH Block Grant application, as well as oversees the MCH Needs Assessment process. The Bureau works with BLC on emergency medical services, certifying WIC Clinics laboratory work, and on Newborn Intensive Care Unit regulations, which they regulate. Finally, the BEIS which is co-located with the BFHS works closely with the Children with Special Health Care Needs (CSHCN) Program and other Bureau initiatives. Title V funds support the BEIS services. The Bureau also supports the multi-disciplinary specialty clinics held in BEIS facilities.

[47] Title V Block Grant Application, State: NV, Application Year: 2008, http://health2k.state.nv.us/docs/MCHApplication2008.pdf

[48] Nevada, The MCH Federal-State Partnership, https://perfdata.hrsa.gov/mchb/mchreports/TVISReports/UI/Snapshot/snapshot.aspx?statecode=NV

Maternal and Child Health Advisory Board

The Maternal and Child Health Advisory Board (MCHAB) advises Nevada's MCH Program. The MCHAB was first established through an executive order in 1989. This original Board was formed as a 24-member body to provide the Governor with critical information and recommendations for the planning and provision of health services for women, infants, children, and their families. In 1991, the Nevada State Legislature passed Assembly Bill 327 (NRS 442.133) to establish the current Board as an 11-member body: nine members to be appointed by the Governor, one member of the Senate, and one member of the Assembly. Its composition represents public health, providers, legislators and a consumer who always represents CSHCN. Per NRS, the MCHAB is advisory to the Administrator of the NSHD. They meet four to six times a year, alternating between Reno and Las Vegas, and more frequently now by videoconference. They respond quickly to issues as they come up and testify before the Legislature on bills of concern to the Department. They produce a bi-annual report. The MCH Bureau Chief staffs the MCHAB.

> *The purpose of the advisory board is to advise the administrator of the Health Division concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning initiatives to improve the health of pre-school children, to achieve the following objectives:*
>
> 1. *Ensuring the availability and accessibility of primary care health services;*
> 2. *Reducing the rate of infant mortality;*
> 3. *Reducing the incidence of preventable diseases and handicapping conditions among children;*
> 4. *Identifying the most effective methods of preventing fetal alcohol syndrome and collecting information relating to the incidence of fetal alcohol syndrome in this state;*
> 5. *Preventing the consumption of alcohol by women during pregnancy;*
> 6. *Reducing the need for inpatient and long-term care services;*
> 7. *Increasing the number of children who are appropriately immunized against disease;*
> 8. *Increasing the number of children from low-income families who are receiving assessments of their health;*
> 9. *Ensuring that services to follow-up assessments are available, accessible and affordable to children identified as in need of those services; and*
> 10. *Assisting the Health Division in developing a program of public education that is required pursuant to NRS 442.385, including, without limitation, preparing and obtaining information relating to fetal alcohol syndrome;*

11. *Assisting the University of Nevada School of Medicine in reviewing, amending and distributing guidelines it is required to develop pursuant to NRS 442.390; and*
12. *Promoting the health of infants and mothers by ensuring the availability and accessibility of affordable perinatal services."*

In summary, comprehensive prevention has been and remains the focus of the Board. This includes the prevention of teen pregnancy, prematurity and low birth-weight babies. It includes preventing substance abuse in pregnant women. It means preventing dental disease and promoting good oral health, and access to primary care, including dental care, and mental health services for all Nevada families, all the components that make up a medical home. The need for an ongoing source of health care, defined as a medical home, for all children, including children with special health care needs, is a priority at the national level, and Nevada should be no different.[49] The child without a medical home who is not healthy physically, mentally, and/or has poor oral health cannot grow and develop properly, or be successful in school. Good health can only occur if there is access to good preconception and pregnancy care with healthy births for mothers and support after birth, along with primary care, dental care, and mental health medical homes for all children and their families, including children with special health care needs. To have healthy children in healthy families, a continuum of comprehensive, culturally appropriate services is needed statewide.

Year 2005 Nevada Five-Year Needs Assessment

Nevada's five-year Needs Assessment identifies the need for preventive and primary care services for pregnant women, mothers, and infants, preventive and primary care services for children, and services for Children with Special Health Care Needs. 2006-2010 priority needs identified by Nevada's Title V Maternal and Child Health Program are:[50]

1. *Increase access to primary care services, providers, facilities, resources, and payer sources among the MCH populations;*
2. *Increase access to oral health services, providers, facilities, resources, and payer sources among the MCH populations;*
3. *Increase access to mental health services, providers, facilities, resources, and payer sources among the MCH populations;*
4. *Create a unified data system and surveillance system to monitor services delivered to the MCH populations;*
5. *Create continuous, comprehensive services for CSHCN resources in Nevada;*
6. *Increase financial coverage and decrease financial gaps for health care including dental and mental health care among the MCH populations;*
7. *Decrease the incidence of domestic violence among women of childbearing age;*

[49] American Academy of Pediatrics, Policy Statement, Pediatrics Vol. 110. No. 1 July 2002.
[50] Nevada Five-Year Maternal and Child Health Needs Assessment Report 2006 – 2010, 2005, pp 9-10.

8. *Decrease the risk factors associated with obesity for children and women; and*
9. *Decrease unintentional injuries among the MCH populations.*

Based on the above priority areas, eight measurable State-Negotiated Performance Measures were created:

1. *The percentage of women of childbearing age who receive screening and assistance for domestic violence should be increased.*
2. *Access to preventive oral health services for the Medicaid population of children and youth should be increased.*
3. *Obesity among women ages 18 to 44 should be decreased.*
4. *Teen birth rates (per 1,000) among Hispanic adolescents ages 15-17 should be reduced.*
5. *All infants born in the state will have a newborn hearing screening prior to discharge from the hospital.*
6. *The percent of children and youth ages birth through 18 who die from unintentional injuries should be decreased.*
7. *Increase the ratio of primary care providers to the number of children and youth ages birth to twenty-one and women of child-bearing age.*
8. *The percent of women (18-44) who feel down or depressed should be decreased.*

The areas of most concern for the three MCH populations, and perhaps the state as a whole are: oral/dental health care, mental health services, and access to primary care services. Nevada has been the fastest growing state in the United States for the last 17 years. The rapid population growth has presented continuing challenges and added demands on the health care system in relation to both access to and quality of care. Beside the population growth, the demography of Nevada also presents challenges to improving access to health care. Of Nevada's 17 counties, Clark and Washoe are considered urban with approximately 87 percent of the population; Carson City and Elko are designated as a Small Metropolitan Area. Douglas, Lyon, and Storey counties are rural; and Esmeralda, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine are frontier counties.

The rural and frontier residents, while comprising a small portion of the state's population, often require unique responses to their health care needs. Rural and frontier residents are generally older, poorer, and have fewer health resources than their urban counterparts. Given the provider shortages that are common in many rural areas, some rural clients drive over one hundred miles to access care. With the dispersion of the rural population, trained providers confront financial difficulties in maintaining a viable practice for small client populations. In addition, they experience the difficulties of isolation from professional support and the specialty services their clients may require. Overall, there needs to be more communication

and less fragmentation of services between policy-makers, state agencies, health systems, tribal health systems, and between some public and private providers in the state of Nevada. It is essential to have the data needed to educate policy-makers who make funding decisions on local, state, and national level. This will help forge the path necessary to build and strengthen the current public health system as Nevada moves into the future.

Component Area: Medical Home and Health Insurance

Maternal Child Health Line

To help ensure that children are connected to a Medical Home the Nevada MCH Title V program has created the Maternal Child Health Line, 800-429-2669, as a toll-free information and referral (I & R) call-center for Nevada's families. This I & R call-center provides resources for families to make connections with family health practitioners and other family service practitioners in their own communities. The Health Line also plays an essential role in linking families with insurance providers (Medicaid, and Nevada Check Up programs), the women and infants WIC program and other resources for children identified as needing community based services and referrals.

The Health Line also provides an educational campaign that is designed to educate pregnant women and families on the importance of early and continuous prenatal care and the importance of establishing a continuous relationship with a pediatric health care provider for their infants and children.

Primary Care Development Center Initiative

Nevada's MCH, Title V program, in collaboration with federal, state, and local partners, realizes the critical role public and private programs have in assuring that children and families receive health care through a medical home. A Medical Home is:

. . . not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a Medical Home receive the care that they need from a pediatrician or physician (pediatric health care professional) whom they trust. The pediatric health care professionals and parents act as partners in a Medical Home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential. [51]

A first step to addressing medical homes is the Medical Provider shortage experienced by most communities in Nevada. Therefore, Nevada's MCH, Title V has developed the Primary Care Development Center (PCDC) initiative. This initiative acts as a catalyst to bring needed health practitioners to Nevada's rural and frontier counties and some areas of Clark and Washoe Counties. Their mission is to improve access and availability to primary health care services for the underserved rural areas of the state.

The PCDC brings together family physicians, pediatricians, physician assistants, nurse practitioners and others to work in the more rural areas under the management of the Federal Quality Health Care (FQHC) Centers. The health care practitioners involved in

[51] American Academy of Pediatrics, Medical Home Policy, 2002

this program are fulfilling the National Health Service Corps, state loan, and J-1 Visa Waiver program service obligations. They provide a substantial portion of the health care provider workforce in the rural and frontier areas of Nevada. The Health Centers also employ practitioners in a few persistent poverty urban areas of Carson City, Clark County (Las Vegas) and Washoe County (Reno). There are still a significant number of vacancies, especially within the more rural areas of the state.

Oral Health Program

The Nevada State Oral Health Program is a statewide program under the Bureau of Family Health Services (BFHS) in Nevada's Health Division. The program is funded through a variety of sources including a grant from the Human Resources and Services Administration.

(HRSA) Maternal and Child Health Bureau (MCHB), Maternal and Child Health (MCH) Block Grant funds and a cooperative agreement with the Centers for Disease Control and Prevention (CDC) who provided funds for capacity development.

A thirteen member Oral Health Advisory Committee (OHAC) provides advice and assists the Oral Health Program in developing, implementing and evaluating program activities. Members of the OHAC currently represent the State Board of Dental Examiners, Nevada Dental Association, Nevada Dental Hygienists' Association, University of Nevada Las Vegas, School of Dental Medicine (UNLV SDM), Miles for Smiles, the Take Care-A-Van, the Washoe and Clark County Health Departments, tribal health centers, seniors, the developmentally disabled and the faith-based communities.

There are numerous agencies and organizations throughout Nevada working to improve oral health status. Currently six coalitions or variations on coalitions exist in Nevada with a primary focus on oral health. They include the OHAC (statewide), the Northern Nevada Dental Coalition for Underserved Populations (Washoe County), Lyon County Healthy Smiles, Inc. (Lyon County), the Elko Oral Health Coalition (Elko County), the Community Coalition for Oral Health (Clark County) and the Tooth Fairy Council (children's oral health in Clark County). Each group shares activities and information with the other groups.

The Oral Health program promotes optimal oral health, prevention, and control of oral diseases by promoting personal responsibility and improving access to affordable, high quality care. The program accomplishes this through the development and distribution of educational materials, healthcare provider trainings, partnerships with healthcare organizations for dental sealant programs, and the promotion of community water fluoridation. This program is funded using Title V funds and other federal grants**.**

Newborn Screening Program

The Newborn Screening Program is one of the top programs for Newborn Screening in the nation. Ninety-eight to ninety-nine percent of Nevada's newborns are screened to detect diseases early, preferably before the onset of symptoms, so timely treatment can be initiated. Every child born in Nevada is screened for 32 different types of disorders. All children found by the screening process are referred to Early Intervention Services, the Children's Special Health Care Needs program, and WIC for ongoing follow-up and coverage of medical services and special formula. The Nevada program also links families with a metabolic specialist for follow-up. It advocates with the Nevada Medicaid

program for program coverage of special formulas for individuals with these disorders, even into adulthood, as these disorders cause lifelong problems.

Nevada Birth Outcomes Monitoring System (formerly Birth Defects Registry)

Another program provided by Nevada's MCH Title V program is Nevada Birth Outcomes Monitoring System (NBOMS). It is an "active" registry, collecting information primarily from hospital records. NBOMS staff has completed all of FY 2006 data collection, giving the state two full years of data. Medical Associates (connected with the University of Nevada School of Medicine) are contracted to provide multi-disciplinary clinics for CSHCN that include Genetics, and Fetal Alcohol Syndrome Clinics. MCH also supports the Cleft/Craniofacial clinic in Reno.

The Bureau of Family Health Services, in partnership with UNSOM, established a Fetal Alcohol Syndrome (FAS) multidisciplinary clinic in Las Vegas and plans for another FAS clinic in Northern Nevada.

Newborn Hearing Screening Program

A Newborn Hearing Screening Program also is provided through Nevada's MCH Title V program. This program ensures all Nevada newborns are screened for hearing loss. To ensure the continued success of the newborn hearing program, the State MCH program has:

- provided training to hospitals to provide information on the importance of newborn screening, screening technologies and equipment, and the applicable requirements;
- developed educational brochures and supplied them to hospitals and birthing centers to inform parents about newborn hearing screening, early intervention services available for children with a hearing loss, and how to watch for signs of hearing loss that may occur later in childhood.

Infants who "fail" the initial Newborn Hearing Screening are referred to their primary care physician and to the Early Intervention clinics for further evaluation. Families needing financial assistance are referred into the Children with Special Health Care Needs (CSHCN) program, which can cover the costs associated with surgery and hearing aides if needed, and help families get Medicaid or Nevada Check Up.

Children with Special Health Care Needs

The Children with Special Health Care Needs (CSHCN) program is home to a small program that is payer of last resort for the treatment of CSHCN. This program acts as a safety-net provider for eligible individuals who do not meet the eligibility requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada Check Up (Nevada's S-CHIP program). For covered children the program will pay for specialty and subspecialty care, nutrition, primary care, and dental care if the child does not have insurance.

The other portion of the Children with Special Health Care Needs (CSHCN) program is designed to look at the development of family-centered, culturally competent, continuous, and comprehensive services for the broader group of children who fall under the CSHCN definition. CSHCN are those children 0-22 years old and who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions that require health and related services beyond those typically needed by

children in the state. The Real Choice Systems Change (RCSC) grant program, which was funded by the Centers for Medicare and Medicaid, launched the work on changes in the systems of supports and services for CSHCN. The grant ended in 2006, but CSHCN staff continues to address the highest identified needs. These needs include:

a) complex financial application process;

b) lack of information and misinformation (occurring at all levels of expertise– parents, social service providers, and professionals);

c) coordination of services,;

d) transportation;

e) transitioning youth and inclusion in the community; and

f) participation of CSHCN and their families in health care decisions and service development.

Activities build culturally appropriate, community-integrated, family-focused services and supports for Nevada's children with special health care needs who are between birth and 22 years of age.

Component Area: Mental Health and Social-Emotional Development

Perinatal Substance Abuse Prevention Program

The Perinatal Substance Abuse Prevention, (PSAP) program seeks to prevent perinatal substance abuse and to improve effects upon children through coordination of existing resources in the state and through development of new resources. The Initiative is largely comprised of the efforts of the PSAP Subcommittee of the MCH Advisory Board and the PSAP Coordinator. Through this program's web site, families can learn about substance abuse and the harmful effects of alcohol, tobacco or drugs use on fetal development. The site also has easily accessible links to a "Nevada Resources" program that provides information on resources available to specific communities, including information on how to contact treatment programs.

Component Area: Early Care and Education

The Early Childhood Comprehensive System Program is housed within the Nevada State Health Division, Bureau of Family Health Services. Through funding from the CISS, State ECCS grant the Nevada ECCS Program provides the framework for developing cross-linkages and communications between state, county, non-profit and other groups to improve the status of child birth thru five years old in the state of Nevada.

Component Area: Family Support and Parenting Education Program

Women, Infants and Children

The Women, Infants and Children (WIC) program is a federally funded short-term nutrition program operated in Nevada though the Nevada State Health Division, Bureau of Family Health Services. Its objective is to improve the health of Nevada women, infants and children who are eligible for the program by providing supplemental nutritious foods, nutrition education, and other health and social services.

Injury Prevention

The Injury Prevention program, which is funded by the CDC, is designed help reduce injury, disabilities and death due to intentional and unintentional injuries by helping families remain safe in their home, safe on the move, safe at school, safe at work and safe in their communities. Unintentional injuries are the leading cause of death for children ages five through 18 in Nevada.

MCH Women's Health Program

The MCH Women's Health program provides funds that help support access to prenatal and postnatal care for mothers-to-be, new mothers and infants to their first birthdays. Women's Centers in northern and southern Nevada provide routine prenatal and high-risk obstetrical care to women who do not meet other eligibility criteria for health care coverage. Through the University Medical Center Community Health Nurse in southern Nevada and the Renown Pregnancy Center in northern Nevada, obstetricians, pediatricians, family practice doctors and certified nurse midwives are available to work with parents to provide needed care. Childbirth and Parenting education classes are also offered through these programs as well as resource and referral services. Physicians in private practice and OB/GYN residents and other health and service practitioners have combined their resources to provide quality health care to families and their children.

Early Childhood Comprehensive Systems Best Practices

School Readiness

When we discuss the concept of school readiness, we are talking about more than ensuring that a child has enough pencils or gets to the bus on time. School readiness entails all of the factors that help to prepare a child to enter school and make the most of his or her education.

> *School readiness is a term used with increasing frequency to describe expectations of how children will fare upon entry to kindergarten. School readiness encompasses children's curiosity and enthusiasm for learning, their physical and mental health status, their ability to communicate effectively, their capacity to regulate emotions, and their ability to adjust to the kindergarten classroom environment and cooperate with their teachers and peers. Life experiences directly impact a child's development of these foundational skills and competencies beginning at birth and continuing through childhood. Young children are highly influenced by their relationships with adults, by the environment where they live, and by the opportunities they have to play, learn, and grow.*[52]

The National Governor's Association Task Force on School Readiness incorporated three critical elements for defining school readiness:

1. Children's readiness for schools;
2. Schools' readiness for children, and
3. Capacity of families and communities to provide developmental opportunities for their young children.

The task force further defines "school readiness in terms of the 'whole child,' incorporating children's health and physical well-being, their cognitive, social and emotional development, language and literacy skills, and other areas or "domains" that are the foundations for later learning."[53]

The direct implication for early care and education on school readiness is for quality programs. High-quality programs can lead to dramatic benefits for children in terms of school readiness, later school achievement, and lifelong success, and thus yielding a positive return on investment for society. Every $1 invested in high-quality early education and care programs for disadvantaged children saves as much as $17 down the road, with tangible results measured by lower crime, fewer teen parents, and higher individual earning and education levels.[54]

However, the majority of program settings are not of high quality. Children, who experience mediocre or low-quality care, do not demonstrate significant gains, and in

[52] Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth and Families, National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*, ed. Jack P. Shonkoff and Deborah A. Phillips (Washington, D.C.: National Academy Press, 2000)

[53] Final Report of the National Governors' Association Task Force on School Readiness, *Building the Foundation for Bright Futures,* 2005.

[54] United Way, "Success By 6", July 2005; Schweinhart, L.J. 2004. *The High/Scope Perry Preschool Study through age 40.*

some situations, may be at developmental risk or actual danger. Therefore, program improvement is needed.

Quality early childhood care and education programs enhance cognitive, emotional and social development, especially among low-income preschoolers.[55] Studies have demonstrated the effectiveness of quality early childhood education programs, particularly for children in poverty. Participation in such programs can lead to immediate gains in cognitive test scores, better kindergarten achievement, lowered rates of grade retention and special education placement and higher rates of high school graduation.[56]

To address the issues of quality, the National Association for the Education of Young Children (NAEYC) in 2005 released the ten standards that define excellent early child care and education programs for young children. [57] These are:

1. ***Relationships***

   The program promotes positive relationships among all children and adults to encourage each child's sense of individual worth and belonging as part of a community, and to foster each child's ability to contribute as a responsible community member.

2. ***Curriculum***

   The program implements a curriculum that is consistent with its goals for children and promotes learning and development in each of the following domains; aesthetic, cognitive, emotional, language, physical, and social.

3. ***Teaching***

   The program uses developmentally, culturally, and linguistically appropriate and effective teaching approaches that enhance each child's learning and development in the context of the program's curriculum goals.

4. ***Assessment of Child Progress***

   The program is informed by ongoing systematic, formal, and informal assessment approaches to provide information on children's learning and development. These assessments occur within the context of reciprocal communications with families and with sensitivity to the cultural contexts in which children develop. Assessment results are used to benefit children by informing sound decisions about children teaching, and program improvement.

5. ***Health***

   The program promotes the nutrition and health of children and protects children and staff from illness and injury.

[55] Kaman & Neuman, 1997.

[56] Barnett,W.S. (2001). Preschool education for economically disadvantaged children: Effects on reading achievement and related outcomes. In S.B. Neuman & D.K. Dickinson (Eds.), *Handbook of early literacy research* (pp. 421–443). New York: Guilford Press.

[57] National Association for the Education of Young Children; Program Standards, 2005

6. ***Teachers***

   The program employs and supports a teaching staff that has the educational qualifications, knowledge, and professional commitment necessary to promote children's learning and development and to support families' diverse needs and interests.

7. ***Families***

   The program establishes and maintains collaborative relationships with each child's family to foster children's development in all settings. These relationships are sensitive to family composition, language and culture.

8. ***Community Relationships***

   The program establishes relationships with and uses the resources of the children's communities to support the achievement of program goals.

9. ***Physical Environment***

   The program has a safe and healthy environment that provides appropriate and well-maintained indoor and outdoor physical environments. The environment includes facilities, equipment, and material to facilitate child and staff learning and development.

10. ***Leadership and Management***

    The program effectively implements policies, procedures, and systems in support of stable staff and strong personnel, fiscal, and program management so that all children, families, and staff have high-quality experiences.

Thus, the program characteristics that relate to good outcomes for children and form the standards or quality criteria for Best Practices fall into three categories:[58]

- Structure

  Group size and staff-child ratios

- Staff qualifications

  Teacher's formal education, specific training, experience and turnover, and administrators' experience

- Program dynamics
  - Curriculum integrated across developmental areas (cognitive, language, approaches to learning, social, emotional, etc.);
  - Nature of the learning environment – teacher-child interactions, positive teacher behaviors, small group activities, and implementation of the curriculum;
  - Engagement of parents-especially in educational activities at home with their children, reading to children, talking with them.

[58] United Way, "Success By 6", July 2005; Schweinhart, L.J. 2004. *The High/Scope Perry Preschool Study through age 40.*

Transition to Kindergarten Practices

The National Education Goals Panel in 1998 set forth the goal that by the year 2000 all children in America would start school ready to learn. Despite the conviction that transition is a key factor of school readiness, the panel stated that "transition activities ... are the exception rather than the rule in our public schools."[59] Transition to kindergarten involves connections between many different spheres including individual children, families, schools and communities. In order to facilitate a successful transition, the connections between the spheres must be fostered.[60] A smooth transition into kindergarten and formal schooling can help set young children on a course for academic achievement and success. For many five-year-olds, the transition from preschool or home to kindergarten can be stressful. Children face new expectations for independence and responsibility as well as goals that are more formal than those currently used in preschool. They also must learn to interact with teachers in ways that involve academic progress and to negotiate more formalized routines. They often face larger class sizes.

The Head Start Transition Study found that the more frequently kindergarten teachers used certain transition practices, the lower child stress was during the first month of school. [61] Practices included training parents to use their rights and responsibilities in schools, creating support groups for parents, distributing book lists, and recommending activities for parents to carry out with their children during the summer before kindergarten.

Although little experimental research has been done on specific school transition practices, recommendations can be made using theory based on the findings that do exist:

- There should be contact between kindergartens and preschools so that kindergarten teachers can plan for individual students and so that children know what to expect during the transition;
- There should be contact between schools and homes, both before and after entry into school, so that parents can be actively involved in their children's education;
- There should be connections between communities, schools and community resources so that children can receive the services they need as soon as possible.

A smooth transition into kindergarten and formal schooling can help set young children on a course for academic achievement and success.[62]

[59] The Transition to Kindergarten: A Review of Current Research and Promising Practices to Involve Families, Marielle Bohan-Baker and Priscilla M. D. Little, Harvard Family Research Project, April 2002.

[60] University of North Carolina at Chapel Hill, *National Center for Early Development and Learning Spotlights*, No.35 March 2002, Rimm-Kaufman & Pianta, 1999.

[61] Lessons from Three Decades of Transition Research, Sharon L. Kagan, Michelle J. Neuman, *The Elementary School Journal*, Vol. 98, No. 4, Special Issue: Transitions (Mar., 1998), pp. 365-379.

[62] Child Trends, Background for Community-Level Work on School Readiness, 2000

Medical Homes

A Medical Home is primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. A Medical Home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care.[63]

The need for an ongoing source of health care - ideally a Medical Home - for all children has been identified as a priority for child health policy reform at the national and local level. The U.S. Department of Health and Human Services' Healthy People 2010 goal1 is to improve access to comprehensive, high-quality health care services.

In addition, the Future of Pediatric Education II goals and objectives state: "Pediatric medical education at all levels must be based on the health needs of children in the context of the family and community" and " all children should receive primary care services through a consistent *Medical Home*." Over the next decade, with the collaboration of families, insurers, employers, government, medical educators, and other components of the health care system, the quality of life can be improved for all children through the care provided in a Medical Home.[64]

In a Medical Home, a pediatric clinician works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family.[65]

Physical Health and Well Being

Physically healthy children are able to engage in the full range of life experiences that promote early learning. Children's motor skills and coordination have an important influence on their cognitive and social-emotional development, as well as their academic achievement. Young children's cognitive development depends on active, physical exploration. [66] Motor skills support an infant's cognitive need to explore and to manipulate objects and a toddler's social-emotional need to safely keep up with peers and to gain independence with self-help tasks. Children develop concepts about objects through manipulation and learn about their world by moving through the space around them. Children use all their senses (touch, movement, smell, taste, vision, and hearing) to collect information about their world. Progressively, children learn to think symbolically and logically about their experiences. Cognitive development occurs as children explore and test a variety of ideas and newly learned concepts.

Children who have a regular source of health care are more likely to receive immunizations, preventive health care, and developmental services in a timely manner, thereby increasing their chances of good health when they enter school. Children without health insurance often experience delays in receiving required immunizations

[63] American Academy of Pediatrics, Medical Home Policy, 2002
[64] The Future of Pediatric Education II, *A Project of the Pediatric Community, American Academy of Pediatrics.1998*
[65] American Academy of Pediatrics, Medical Home, Pediatrics.2002; 110: 184-186.
[66] *"Guidelines for Best Practices in Determining Eligibility Based on Children's* Cognitive Development", Waisman Center, Early Childhood Unit, Madison, WI, www.waisman.wisc.edu

and other preventive health services as compared to their insured peers, potentially resulting in long-term health problems. Research demonstrates that uninsured children are at an elevated risk for absenteeism and prolonged illnesses, both of which could negativity impact their school readiness and academic achievement. [67]

Based on extensive review of scientific literature and research, best practices according to the American Academy of Pediatrics' "Bright Futures" program recommends these guidelines for health supervision of infants, children, and adolescents:

- promote the physical, emotional , intellectual, and social health, safety, and well-being of children and adolescents in the context of their family and community;
- view health from a developmental perspective, providing a continuum of care as children progress through the developmental milestones and challenges of childhood, from birth through adolescence;
- nurture a trusting partnership between the health professional, the child, the adolescent, and the family;
- recognize that families know their children best and are important partners in health promotion and disease prevention;
- acknowledge the impact of the family and the community on the health of the child;
- realize that health promotion is everybody's business and requires the participation and commitment of many community partners;
- promote improved health and developmental outcomes as well as increased personal responsibility and social competence. [68]

Social and Emotional Health

Research about early brain development, tells us that a child's earliest experiences set the stage for how he or she relates to others, feels about him or herself, and manages impulses and emotions. Most young children develop emotional competencies and skills, such as, learning to talk about their feelings, learning to share, learning to trust adults, engaging fully in play. This assist them to make the transition to kindergarten successfully. [69]

Consistent with the idea that early childhood mental health systems reflect a combined public health/mental health mode, it is important for those developing such systems to think about the characteristics that are likely to promote effective practice. The experience of investigators in this area suggests that developing services and service systems be: grounded within developmental knowledge, relationship-based, family supportive, and infused into the existing early childhood networks. Also, services need

[67] (Kagan, S.L., Moore, E. and Bradekamp, S., *Reconsidering Children's Early Development and Learning: Toward Common Views and Vocabulary.* Washington, DC National Education Goals Panel, 1995) (Newacheck, P.W. et al.) *Health Insurance and Access to Primary Care for Children,* New England Journal of Medicine, 338(8):513-519, 1998.

[68] American Academy of Pediatrics "Bright Futures" Guidelines for Health Supervision of Infants, Children, and Adolescents, 2nd ed., rev.

[69] National Center for Children in Poverty; *Promoting the Emotional Well-Being of Children and Families, Policy Paper No. 1*, Jane Knitzer, January 2002.

to be responsive to the community and cultural context, as well as attentive to outcomes, especially those related to school readiness. [70]

A growing body of research and practice indicates that a comprehensive approach to the healthy social-emotional development of young children:

- expands the skills of parents, teachers, and other caregivers who nurture and support children;
- ensures early screening and assessment to identify problems early; and
- targets prevention and early intervention services to children who are most at risk.[71]

Comprehensive systems also provide a continuum of opportunities, interventions, and supports for children with identified mental health problems or disorders, and their families.

Families' Basic Needs and Effective Parenting

In the context of a School Readiness Initiative, family support and parenting reflects a comprehensive approach addressing the broader issues that affect family functioning and parents' ability to support their children's health development and learning potential.

A family's basic needs are based on having incomes above 200 percent of the federal poverty level. This is needed to supply such needs as food, housing, health care, child care, transportation, and other necessities.

Families with incomes below 200 percent of the federal poverty level-the amount that research suggests is needed for most families to be economically self-sufficient-exacts a measurable toll on children's overall healthy development.[72] The intellectual, social-emotional, and physical development of children in low-income families have been shown to lag behind that of their more affluent peers.

The federal poverty level for a family of four is $18,400 (as of November 2003). Twelve million children live in such families in this country. However, the numbers are far worse. Double the income that is considered "poverty" is needed for most families to provide their children with necessities like adequate food, stable housing, health care and quality child care, transportation and other necessities.[73]

It is critical that families have sufficient income to support their children. Policies that help low-income parents meet the material needs of their children, such as, increase in the minimum wage, expansion of the federal Earned Income Tax Credit, decrease of payroll tax burden on low-wage workers, and health insurance for working parents must be developed.[74]

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[70] National Center for Children in Poverty; Promoting the Emotional Well-Being of Children and Families, Policy Paper No. 1, Jane Knitzer, January 2002

[71] UCLA, center for Healthier Children, Families and Communities, 2004.

[72] Employment Alone is Not Enough for America's Low-Income Children and Families National Center for Children in Poverty, Nancy K. Cauthen and Hsien-Hen Lu, August 2003 http://www.nccp.org/

[73] National Center for Children in Poverty; Living at the Edge, Research brief No.4, Elizabeth Gershoff, November 2003)

[74] Ibid.

Parents are a major influence in the lives of young children and are essentially their first teachers.[75] The combined approach of parent education with a direct, quality early care and education (ECE) program for children has been found to be one of the best strategies for improving child outcomes.

> *Studies indicate that when parents are involved in their children's schooling, children achieve higher grades and better school attendance; they have more positive attitudes and behaviors, higher graduation rates, and greater enrollment in higher education*.[76]

Recommendations for School Readiness Programs:

1. Parenting and family support programs need to be linked to or incorporate all five essential components of a School Readiness Plan; Early care and education, family support services, parenting education, medical homes and mental health.
2. The intensity and duration of services has a significant impact on the ultimate benefit of programs.
3. Programs are more effective when they are tailored to meet the needs of the communities being served.
4. Improving relationships between families and agencies will increase participation in parent and family support programs.
5. Value all levels of parent involvement.
6. Be inclusive of diversity, including children and families with disabilities and special needs.[77]

[75] UCLA Center for Healthier Children; Families and Communities, November 2004.

[76] Henderson, A., & Berla, N. (1994). *A new generation of evidence: The family is critical to student achievement*. Columbia, MD: National Committee for Citizens in Education.

[77] UCLA Center for Healthier Children; Families and Communities, November 2004.

Development of the Nevada ECCS Strategic Plan

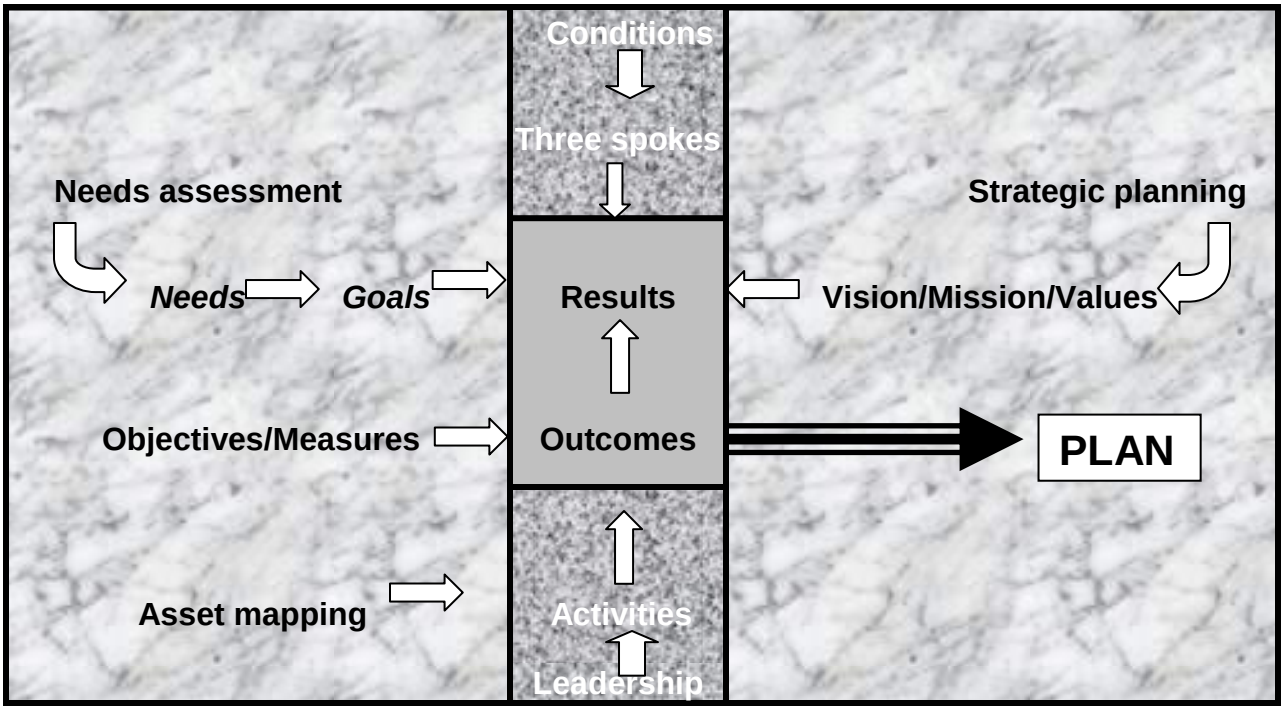
This plan is the result of a collaborative process supported by the State Early Childhood Comprehensive Systems (ECCS) Planning Grant from the Maternal and Child Health Bureau. This award was granted to Nevada State Health Division, Bureau of Family Health Services (BFHS) on July 1, 2003. Initially a two-year planning grant was followed by three-years of additional planning or implementation funds with the intent of building a state-wide plan to guide the development of a seamless system of care for children ages birth to five and their families.

The State Early Childhood Comprehensive Systems grant requires that the plan address children and their families in five distinct yet interrelated domains. These are Early Care and Education, Medical Homes, Social and Emotional Health, Family Support and Parent Education. Through the coordination of services and policies that address these five domains, Nevada can better support the health and development of its children and the future economic growth and success of the state of Nevada.

The Bureau of Family Health Services hired staff to lead the planning process in April 2004. A task force of twenty-three individuals representing state agencies, local agencies, parent advocates, and business leaders was established to guide the planning process. Advisory members who are early childhood experts or invested partners were also invited to join in the dialogue to put together a draft framework for Nevada's Early Childhood Comprehensive System (ECCS) plan.

In August 2004, the first meeting of the ECCS Task Force occurred. At the initial meeting, workgroups formed around the strategic domains of the ECCS initiative. As Nevada has limited resources, the Task Force members decided to combine similar domains resulting in the creation of three workgroups. These workgroups consisted of the Early Care and Education workgroup, the Medical Homes and Social and Emotional Health workgroup, and the Parent Education and Family Support workgroup.

Figure 8: Early Childhood Comprehensive Systems planning model



These workgroups met numerous times throughout 2004 and 2005 to develop recommended work-plans within each of the domains. The Task Force members and advisors met for a two-day ECCS Planning Summit in October 2005. The ECCS Planning Summit was entitled: *Telling a New Story: Creating an Early Childhood Comprehensive System in Nevada.* To ensure that all planning efforts would remain consistent and result in focused-outcomes, the Early Childhood Comprehensive Systems planning model, *Figure 8,* was developed to assist in looking at the "big picture." The model utilized the needs assessment developed in tandem with the strategic plan, thus, allowing a clear vision and mission to be developed. External conditions are taken into account, i.e., current leadership, political will, growth and infrastructure. The findings from this process were used to develop desired results and their ensuing outcomes, activities, and measures.

The Wheel of Change, depicted in Figure 9, shows the relationship between all of the component areas and how they interact to support needed change towards a common vision. As you can see from this figure, the vision is the center of the plan. All results, outcomes and activities for each domain work to support the realization of the vision; however, the results, outcomes and activities are directly influenced by other existing conditions that influence their ability to be successful or not. These conditions may include social norms, political will, economics, advocacy, etc. In order for the wheel to work, three spokes must be in place to support the wheel's ability to navigate through the conditions. These spokes include leadership and development, infrastructure and resources, and communication and evaluation. Without changing, the existing conditions or the spokes needed to support the plan's navigation through these conditions, the likelihood of reaching the vision diminishes.

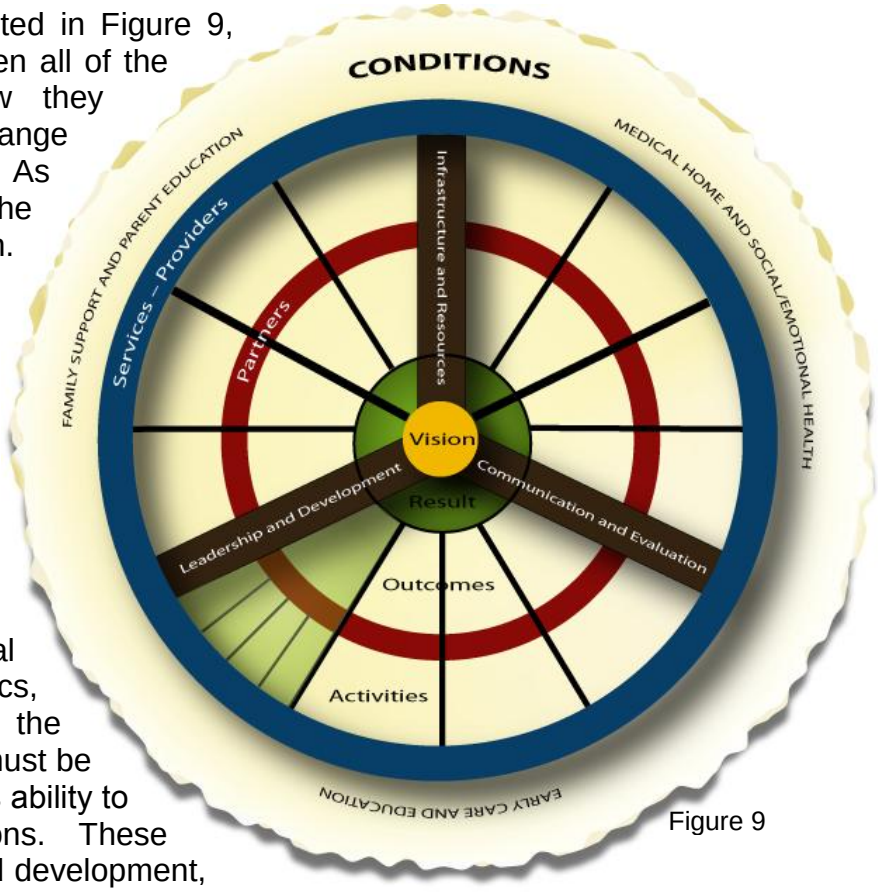


Figure 9

By seeing how the "big picture" must be considered, the Wheel of Change model directs the development of a plan that will affect the entire system. For the state of Nevada to become responsive to young children and their families and to develop a system to support healthy development, it must look towards strategies that influence the entire system, thus allowing programs to have successful activities and outcomes. Only when the spokes, activities, outcomes, and results are aligned with the existing conditions to support young children and their families will Nevada be able to reply to our opening question that, "Our children are well!" From this exercise the group came to consensus for the vision and mission statements for the Nevada's ECCS plan.

Vision

Parents, governmental entities and communities are committed to the children of Nevada, through the development of policies and sustainable resources, which support the education, safety, health and well-being of all children and their families. Thus, all young children in Nevada have access to resources to enable them to grow up as healthy, contributing members of society, resulting in the economic growth and success of the state of Nevada.

Mission

The Nevada ECCS Initiative will facilitate the development of a comprehensive, coordinated system of services for young children and their families to ensure that every child, commencing at birth, receives an equal opportunity to become a well-educated, psychologically sound, contributing member of society, hence leading to the economic growth and success of the state of Nevada.

Defining the Strategic Workplan

So that everyone was on the same page the following definitions were put forward:

- RESULT: A positive CHANGE in the condition of an individual, family, group or community.
- OUTCOME: The building blocks (concrete actions) that must be done (that you will do), and when added together, will achieve the result.
- ACTIVITIES: The specific steps that will be taken to achieve the outcomes. [Output is evidence of service delivery from activities—from Kellogg logic model process]

The work of the initial task force and work groups resulted in a skeleton for the development of Nevada's ECCS Strategic Work plan. Unfortunately, the staff position for the ECCS coordinator was vacant from April 2006 to January 2007, thus resulting in a loss to the momentum. The newly hired Early Childhood Systems Coordinator has been re-engaging former task force and advisory members, as well as recruiting new members. These individuals have been instrumental in providing historical context and status of issues related to the ECCS Strategic Plan. As the workgroups are brought back together, they will begin to move forward on the goals and outcomes for the plan while refining those parts of the plan that still need further development. The 2007-2008 year is important for Nevada to make progress on the plan by further development of the plan with clear action steps for implementation.

The following work plan outlines the result areas, outcomes and activities toward building a leadership team and governance for early childhood issues, as well as addresses how Nevada is coordinating efforts throughout the state in the five key domain areas. Being a dynamic document, the Nevada ECCS Strategic Work plan will evolve as the work progresses and more key partners are brought to the table.

Leadership Development, Communication and Infrastructure

Result 1. Nevada has the resources and political will to adequately support early childhood programs.

Outcome 1A: By Summer 2008, a leadership body will be developed that will ensure that state policies support early childhood programs in such a way that early childhood programs are coordinated and have the needed resources to be effective in the state of Nevada.

Outcome Objective/Measure: *Process measures only.*

	Activities/Strategies	By When	Who	Process Measure
1	Identify key public and private sector organizations throughout the state that can be effective advocates for early childhood issues. These will include both public and private sector representatives.	March 31, 2008	Nevada Public Health Foundation, Task Force members and Health Division staff	List of key persons who accept the responsibility and actively participate
2	Assemble the key representatives to share information, collaborate and advocate for early childhood programs.	April 2008	Nevada Public Health Foundation (lead), Task Force members and Health Division staff	Meeting minutes and list of those attending
3	Review current policy statements, such as NevAEYC policy statements/fact sheets on Full-day Kindergarten, Quality ECE, and Compensation Initiatives and develop new policy statements, as needed, that can be used to build advocacy and support from policymakers on issues related to early childhood issues	Fall of 2007 & ongoing	Nevada Public Health Foundation	Written policy statements. Meeting minutes. Publications; Group structure i.e., by-laws, formal/informal.

Result 2: All agencies/organizations/programs that serve birth to five age children are aware of and knowledgeable about available data and all other services available to assist young children and their families.			
Outcome 2A: By June 2010, improve data communication between agencies and programs that serve children age birth to five.			
***Outcome Objective/measure*:** By July 2010, 75 percent of state agencies that serve birth to five age children will report having easy access to local data and resources.			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1 Identify data sources containing local data that are currently available.	Spring 2008	Health Division Staff and other state/ community partners	List/report of data sources
2 Map assets/gaps/fiscal monies appropriated.	Spring 2008	Health Division Staff and other state/ community partners	Report to share with MCAHB and other stakeholders
3 Develop a central resource from where all agencies can obtain the most current local data. Provide this data to local programs in a useful and understandable way via ECCS website link and/or other links.	Spring 2008		Documentation of the developed resource and the data it contains
4 Identify and secure funding sources to support the above resource.	June 2009		Documentation of process

Outcome 2B: By June 2009, Increase communication among programs that serve children ages birth to five.			
Outcome Objective/Measure*: By June 2009, 80 percent of surveyed programs that serve children ages birth to five will state that there is an9increase in communications among early childhood programs when compared to the prior year.*			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1 Research current communication infrastructure (i.e., newsletters, video conferencing) and determine any technology infrastructure improvements available to enhance communication between early childhood stakeholders. Explore both hardware and software solutions.	March 2007 and ongoing	Health Division Staff & Head Start State Collaboration Office	Communication infrastructure enhancement plan
2 Deploy technology solutions identified above.	August 2008		Acquisition and deployment of technology
3 Work with the NevAEYC, Nevada Registry, on a comprehensive early childhood listserve for all programs in the state of Nevada if deemed effective/efficient.	Sept. 2008	Health Division Staff, in partnership with NevAEYC and Nevada Registry.	Listserv activation
4 Create and distribute an electronic newsletter to inform agencies about the latest research, best practices, programs and early childhood news.	October 2008	Health Division Staff in partnership with NevAEYC in conjunction with partners	At least quarterly distribution of e-newsletter
5 Create, and maintain the Nevada ECCS website.	June 2008 and ongoing	Health Division Staff	Website
6 Work with Nevada 2-1-1 system statewide to assess current status of their referral information and way to insure the 2-1-1 system has the most update referral information	December 2007	2-1-1 & BFHS staff	Working relationship between ECCS program and state 2-1-1 system

EARLY CARE AND EDUCATION

Result 1: **Early care and education services and programs are high quality**.

Outcome 1A: By July 1, 2009 state and local child care licensing regulations will be strengthened.

Outcome Objective/Measure: *By July 1, 2009, state and local agencies will work together to develop a proposal to change educational standards so that they are equivalent to those of Head Start http://www.headstartinfo.org/infocenter/ehs_tkit1.htm, the National Association of the Education of Young Children (NAEYC) http://www.naeyc.org/faculty/college.asp, and Caring for Our Children: National Health and Safety Performance Standards http://nrc.uchsc.edu/CFOC/.*

	Activities/Strategies	By When	Who	Process Measure
1	Identify key stakeholders who can influence child care regulations.	June 2005	Health Division, Office of Early Care and Education, Division of Child and Family Services, Head Start State Collaboration Office, local licensing agencies, licensed child care providers, and other key stakeholders.	List of identified stakeholders
2	Develop a task force of key stakeholders who will thoroughly research and analyze current regulations and make recommendations on how to improve standards.	Dec. 2006		Task Force
3	Develop a strategy to strengthen regulations at state and local levels to match those of Head Start, the NAEYC (National Association of the Education of Young Children) and the National Health and Safety Performance Standards.	Beginning Fall 2007 and ongoing		Licensing regulations that are moving toward best practices are approved by the appropriate board.
4	Implement the strategy to strengthen regulations at the state and local levels.	June 2009		Implementation of regulations

Outcome 1B: Increase standards for educational requirements, skills, compensation and experience of early care and education providers in all settings within the field (e.g., privately owned, non-profit, public pre-k, Head Start, etc.).			
***Outcome Objective/Measures**: By July 1, 2009 eighty percent of child care providers will meet educational standards set in Outcome 1A above.*			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1. Develop a coordinated system of personnel preparation and ongoing professional development including technical assistance for providers and administrators that is competency/learning outcome-based.	July 2008	Early Childhood Comprehensive System Staff, Nevada State Welfare and NevAEYC.	Written framework of coordinated system, MOUs, etc
2. Develop a pilot compensation initiative that supports existing and prospective child care professionals in seeking education and training to enhance their skills.	Contingent on funding for a pilot project.		Description of incentive program and utilization records
3. Implement a coordinated statewide Quality Rating System by making quality more visible and supporting systems that reward and recognize quality.	July 2012		
4. Develop and implement a social marketing campaign to increase parent knowledge about and expectations of quality early care and education so that advocacy efforts and demand for high quality early care and education guidelines/regulations increase throughout Nevada.	Spring 2008		Written marketing plan delineating funding partners for campaign
5. Investigate, develop and secure funding streams, which will sustain all efforts.	July 2008 ongoing		Evidence of increased funding over time

Outcome 1C: Increase availability of child care services and resources that support/nourish families, inclusive of children who have disabilities and other special needs.				
Outcome Objective/Measure: *By July 1, 2009, enrollment in licensed child care settings will increase by at least 10 percent over the number reported in 2006; furthermore, the enrollment of children with disabilities and other special needs in licensed child care settings will increase by at least 10 percent over the number reported in 2006.*				
Activities/Strategies		**By When**	**Who**	**Process Measure**
1	Research and identify all available parent education, family support, and children's services.	Sept. 2007	Health and Human Services Staff, Nevada Child Care Resource & Referral Network. 2-1-1, The Children's Cabinet and the Child Care Assistance Division in Las Vegas, Family TIES	List of organizations and services
2	Build on already existing referral mechanisms to increase the number of parents who access parent education, family support and children's services via referral by early care and education providers. Create a measure to gauge the increase.	Ongoing		Instrument to gauge usage
3	Query partner agencies for parent surveys that measure parent's satisfaction with parent education, family support and children's services.	October 2007		Multiple surveys will be collected and reviewed
4	Develop, administer and interpret results of a survey tool administered to a pilot group of parents.	January 2008		Survey tool and results
5	Develop an education/training program for providers that will increase their ability to integrate children with disabilities and other special health care needs (Any Education/training program needs to be tied into the NV Registry and there should be a connection back to ECE requirements discussed earlier).		UNLV's ECE program within the Special Education division of the Education Dept. and Family TIES.	Program plan and/or curriculum(s)
6	Develop and implement a strategy to increase the number of licensed child care and education settings for all infants and children that are affordable, accredited, culturally and developmentally appropriate.	January 2009	Office of Early Care and Education and CCR&Rs	Written plan and/or meeting minutes incorporated into child development plan

Outcome 1D: Increase child care providers' knowledge of health, developmental and behavioral issues of children by utilizing child care health consultants in partnerships with multi-disciplinary teams.

Outcome Objective/Measures: *By July 1, 2009, child care providers will show a statistically significant increase in their knowledge of health, developmental and behavioral issues.*

	Activities/Strategies	By When	Who	Process measure
1	Identify members of multi-disciplinary teams to develop at model for Health Child Care Nevada, Child Health Care Consultants.	July 2007	Health Division Staff, Office of Early Care and Education, AHEC of Southern Nevada	Team member's commitment and minutes for meetings
2	Develop the Child Care Health Advocate[78] (CCHA) component curriculum as an adaptation of California's or like curriculum.	January 2008	Health Division Staff, AHEC of Southern Nevada	Nevada CCHA curriculum developed
3	Work with state and local Child Care Licensing entities to incorporate regulations for CCHC and CCHA.	Summer 2008	Health Division Staff	Introduction of regulation language changes to the licensing agencies for incorporation
4	Identify strategies to recruit and funding mechanisms to sustain Health Child Care Nevada Initiative.	Spring 2008	Health Division Staff, AHEC of Southern Nevada	Described strategies and funding mechanism and any funding agreements
5	Recruit and train Child Care Health Consultants (CCHC).[79]	Summer 2008 ongoing	Health Division Staff, AHEC of Southern Nevada	List of consultants and records of training and certification
6	Review and revise as needed the tracking mechanism developed by UNR to gather information about utilization of CCHC's and child care providers increased knowledge of health, developmental and behavioral issues.	October 2008	Health Division staff, CCHC workgroup and evaluation team	Tracking Tool
7	Educate and inform child care providers of the Child Care Health Consultants' services.	October 2008	Health Division staff and local health authority staff	List of providers receiving services

Result 2: Formal linkages exist between home, early care and education, and elementary school to provide a smooth transition and continuity of services for all children.

Outcome 2A: Increased linkages between child care providers, schools and parents, ensuring smooth transitions and continuity of services.

[78] *Child Care Health Advocate (CCHA) is an early care and education (ECE) staff person who serves as the on-site coordinator for health and safety issues. This person can work with the staff and ECE program director to identify where health and safety improvements are needed. CCHAs play an important role in improving the health and safety of children and staff in the ECE program.*

[79] Child care health consultants include professionals such as nurses, nurse practitioners, physician assistants, physicians, health educators, dental hygienists, sanitarians, and medical social workers. *They are specially trained to work directly with child care providers in family care homes and centers by providing consulting services on a variety of topics and also act as an information and referral specialist to community resources.*

Outcome Objective/Measure: *Process measures*				
Activities/Strategies		**By When**	**Who**	**Process Measure**
1	Research current state policies to see to what extent they address formal linkages and transitions between home, early care, preschool and elementary grades.	January 2008	Nevada Dept of Education Pre-K and EC Sp Ed Administrators, HSSCO, CCR&Rs	Report of policies needed
2	Work with state policy makers to ensure that state policies facilitate wrap-around child care with part-day preschool programs.	January 2008	HSSCO, Office of ECE, CCR&Rs, etc.	Develop policies as identified above for introduction to policy makers
3	Coordinate with the Early Intervention and child care programs to fund and evaluate pilot programs that provide behavioral specialists for early care settings.	Already exist	EIS, Health Division, HSSCO, ECCS, NDE (Sp Ed)	Map of all services available
Outcome 2B: Increase the knowledge of parents of children with special health care needs about Individual Family Service Plans (IFSPs), Individual Education Plans (IEPs) and transitions to preschool and kindergarten.				
Outcome Objective/measure: *Process measures*				
Activities/Strategies		**By When**	**Who**	**Process Measure**
1	Determine what information is already published and available for parents of children with special health care needs regarding IFSPs, IEPs, and kindergarten transitioning.	Nov. 2007	ECCS, NDE, HSSCO	Materials already in existence will be in one place
2	Working with parent advocacy groups such as Nevada P.E.P., Family Ties and Families Voices, develop a mechanism to collect data showing the current level of knowledge parents of children with special health care needs have.	July 2008	Nevada P.E.P., Family Ties and Family Voices, ECCS and other stakeholders	Mechanism to collect current knowledge of parents of children with special health care needs
3	Assemble parents, advocates, and key community organizations to develop a state supported plan to educate parents about the Individual Family Service Planning process and transition to preschool (IDEA).	Sept. 2008	ECCS workgroup	TBD

Outcome 2C: Encourage businesses to invest in quality child care programs.			
Outcome Objective/Measures: By September 2008, at least two major businesses in Nevada will have developed strategies to support quality early care and education.			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1 Find and utilize or develop economic based fact sheets specific to Nevada regarding the long-term investment benefits of high quality early care and education.	January 2009	HSSCO, ECCS, Nevada Kids Count, Nevada Institute for Children, NevAEYC and OECE	Up-to-date position papers
2 Build a "speakers' bureau" of experts who can represent and speak about the long term investment benefits of high quality early care and education at a moment's notice, as well as at planned events.	January 2009 (in time for next legislative session)	Statewide ECE Team	Speakers Bureau will exist
3 Explore forming a nonprofit organization to house donations and systematize distribution of grant funding for building a comprehensive system of quality early care and education options in Nevada.	Sept. 2009	Statewide ECE Team, Legislators, Senators	Statewide Early Childhood Council or other governing body will exist
4 Work with at least two major businesses in Nevada to develop strategies for them to support quality early care and education.	Sept. 2008	Statewide ECE Team, Legislators, Senators, perhaps, Chambers of Commerce	Results of strategies will be reported in ECCS annual report

MEDICAL HOME/SOCIAL/EMOTIONAL HEALTH

Rationale: *Good physical and mental health during early childhood is important for achieving the cognitive and social components of school readiness, including the ability to engage in the learning process. Lack of access to health insurance and the associated lack of access to a regular source of high-quality health care are associated with the development of preventable conditions and the deterioration of existing conditions that can lead to long-term learning and behavior problems.*

Result 1: All children have a medical [dental] home* that parents will use.

"A Medical Home is primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." (A Medical Home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care.)

Indictors:

1) **immunization rates**
2) **percentage of children who receive well-baby & child checkups**

Outcome 1A: By July 1, 2009, the number of practitioners that incorporate the "seven medical home" model core components will be equivalent to the national average.

Outcome Objective/Measure: *Same as Outcome*

Activities/Strategies	By When	Who	Process Measure
1. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Spring 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
2. Work with state agency and community organizations to establish standards for a medical home.	Summer 2008		Development of standards in Medicaid and Nevada Check Up MCO program HEDIS measures and P4P program
3. Review and/or create methods to identify and assure medical home access to all children 0-5.	Summer 2008		Identified methodology
4. Educate practitioners on ways to incorporate the standards for a medical home into their practice.	Sept. 2009		# of practitioners trained

Outcome 1B: Medical/health care practitioners are knowledgeable and linked to other child and family resources in their communities.				
Outcome Objective/Measure: *By September 1, 2009 medical/health care practitioners will show a statistically significant increase in the number of referrals made to other child and family resources from a baseline collected in Summer of 2008.*				
Activities/Strategies		**By When**	**Who**	**Process Measure**
1.	Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Spring 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
2.	Work with health care practitioners, i.e., UNR Schools of Medicine, Nursing, and Dentistry, Area Health Education Centers, (AHEC), to identify current and/or develop and implement trainings linked with CEUs, where applicable, for practitioners on referral and community linkage for child care and family resources, i.e., prenatal substance abuse screening tool.	Summer 2008		Training calendar
3.	Develop methods of measuring increased knowledge about and use of the information presented in the trainings.	Summer 2008		Pre-post evaluation
4.	Use evaluation method to make changes to training to increase knowledge retention and use of learned strategies.	Summer 2009		Evaluation results and training changes

Outcome 1C: Non-medical home [health] practitioners are knowledgeable and linked to other child and family resources in their communities, including medical homes			
Outcome Objective/Measure: *By September 1, 2009 medical/health care practitioners will show a statistically significant increase in the number of referrals made to other child and family resources, including medical homes, from a baseline collected in Summer of 2008.*			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Summer 2007	Early Childhood Comprehensive System Staff and Health workgroup team, Southern Nevada AHEC	Report of findings
2. Develop training linked with CEUs where applicable for service practitioners to inform them about child and family resources and the importance of children having a medical home.	Summer 2008		Training calendar
3. Develop a method of measuring increased knowledge about and use of the information presented in the training.	Summer 2008		Pre-post evaluation
4. Use evaluation method to make changes to training to increase knowledge retention and use of learned strategies.	Summer 2009		Evaluation results and training changes

Outcome 1D: Parents know about and use a medical home.				
Outcome Objective/Measures: *By August 2009 t*here will be an increase in medical home usage in Nevada by 20 percent from a baseline collected in the 2008 BRFSS.				
	Activities/Strategies	**By When**	**Who**	**Process Measure**
1.	Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Summer 2007	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
2.	Research the availability of current English and Spanish language materials for parents, which addresses the importance of and methods to find a medical home for their children.	June 2008		Report of findings
3.	Work in collaboration with existing medical workgroups/committees at the state and community level to develop culturally/linguistic appropriate outreach material	January 2008	Early Childhood Comprehensive System Staff, Healthy Kids EPSDT Parent Support and Education group.	Appropriate outreach materials
4.	Determine if medical home utilization can be tracked and if there is a measurement tool currently available to develop baseline rates of utilization.	July 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report to Health workgroup in minutes
5.	Establish baseline rates utilizing the above-identified tool or develop a measurement tool if feasible.	September 2008		Useable tool
6.	Track utilization rates, if feasible.	June 2009		Report of rates change from baseline

Result 2: Sufficient numbers of high-quality pediatric and/or family care practitioners are in every region of the state to meet children's needs.				
Outcome 2A: Recruit and retain Medical Practitioners that support underserved medical areas in each community.				
Outcome Objective/Measure: *By July 2009, the number of practitioners in rural areas of Nevada will increase by 20 percent from a baseline established in July 2007.*				
	Activities/Strategies	**By When**	**Who**	**Process Measure**
1	Identify and assemble a group of key stakeholders such as the Great Basin Primary Care Association, Primary Care Development Center, University Medical Schools, Area Health Education Centers and Health Division staff that will develop a plan to increase the number of practitioners in Nevada.	July 2007	Early Childhood Comprehensive System Staff and Health workgroup team	Health Workgroup team members identified and convened
2	Develop strategies to recruit and retain pediatricians or family practitioners who will serve as a "medical home" particularly in the underserved areas of the state.	July 2008		Plan
3	Track increases in numbers of practitioners over time.	Annually		Report of provider numbers
4	Develop strategies to measure quality of care provided.	July 2008		Documentation of measurement strategies with implementation plans

Outcome 2B: Increase reimbursement to health care provider for services to a level that is sufficient to encourage pediatricians/family practice physicians to participate in Medicaid and Nevada Check Up.				
Outcome Objective/Measure: *By July 2009, the number of pediatric/family practitioners participating in Medicaid and Nevada Check Up will increase by at least 20 percent from a baseline established in July 2007.*				
	Activities/Strategies	**By When**	**Who**	**Process Measure**
1.	Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Summer 2007	Early Childhood Comprehensive System Staff and Health workgroup team, Division of Health Care Financing and Policy (DHCFP)	Report of findings
2.	Determine if market rates for reimbursement and/or pediatric charges are already available. If they are not, explore the feasibility of conducting a market rate study through an appropriate agency.	Summer 2008		Report on market rates
3.	Use market rate data to determine whether reimbursement levels of public insurance providers are sufficient to encourage pediatricians to participate in Medicaid and Nevada Check Up.	Fall 2008		Report to Health workgroup
4.	Based on findings, develop strategies to bring reimbursement rates up to parity with market rates.	June 2009		Rates at parity
5.	By increasing the practitioners' knowledge of the "clean claim" (electronic) reimbursement format that can turn around in 48 hours, more practitioners will be willing to participate in Medicaid and Nevada Check Up. *Practitioners trainings are offered by First Health*.	June 2009	DHCFP provider training information at: https://nevada.fhsc.com/providers/training/training.asp#catalog	Increase in Medicaid and Nevada Check Up providers
6.	Ensure that health care coverage provides for a medical home reimbursement.	2010	Early Childhood Comprehensive System Staff and Health workgroup team, Division of Health Care Financing and Policy (DHCFP)	Report of strategy to ensure medical home model is reimbursable

Result 3: All children enroll in public or private health insurance programs.[80]

Outcome 3A: Health care practitioners and insurers make high quality, comprehensive health care (including preventive, acute, emergency, and chronic care) available, accessible, and affordable to all infants and young children.

Outcome Objective/Measure: *By January 2010, the number of children who have some type of health care insurance will increase by at least ten percent from a baseline established in 2007.*

Activities/Strategies	By When	Who	Process Measure
1. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Summer 2007	Early Childhood Comprehensive System Staff, Health workgroup team, Nevada Covering Kids and Families	Report of findings
2. Work with public and private health insurance agencies to determine barriers and develop strategies that would allow eligibility determination for Medicaid and/or Nevada Check Up to be completed using coordinated application process. Development of a single online application process.	Working toward this[81]		Report of findings
3. Ensure that health care coverage provides for a medical home reimbursement.	2010	Early Childhood Comprehensive System Staff and Health workgroup team, DHCFP	Report of strategy to ensure medical home model is reimbursable
4. Collect data on current number of insured children and families along with trends with employers throughout the state.	Summer 2008	Early Childhood Comprehensive System Staff, Health workgroup team, Nevada Covering Kids and Families, DHCFP	TBD
5. Develop policies and procedures that allow for the sharing of appropriate information across systems and among service providers.	Summer 2009		TBD
6. Develop hospital based health care coordinators to link children with a health home, enroll children in insurance programs as needed, facilitate links with community based health care sites, family resources center, and state or school based health programs.	Summer 2009		TBD

[80] PEDIATRICS Vol. 113 No. 5 May 2004, pp. 1493-1498, ***The Medical Home, Access to Care, and Insurance: A Review of Evidence***, Barbara Starfield, MD, MPH and Leiyu Shi, DrPH, MBA , From the Department of Health Policy and Management, Johns Hopkins University School of Public Health, Baltimore, Maryland

[81] Nevada Medicaid and Nevada Check Up refer to each other if client is not eligible for services through the first program applied for.

Outcome 3B: Minimize barriers to public and private health care coverage through outreach, simplified rules, and other improvements.			
Outcome Objective/measure: *Process measures*			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Summer 2007	Early Childhood Comprehensive System Staff, Health workgroup team,	Report of findings
2. Support outreach organizations, such as "Nevada Covering Kids and Families," which have expertise and experience in outreach to enroll children in Medicaid, Nevada Check Up and other plans. Assist in developing sustainable outreach processes throughout all community stakeholders.	Ongoing	Nevada Covering Kids and Families	Report by Nevada Covering Kids and Families on outreach activities
3. Work with FRC and other social service organizations to facilitate access to heath services (i.e., child care, transportation, translation).	Ongoing	Parent/family support ECCS workgroups	Number of referrals made
4. Advocate for universal access to health care for all children birth to five years old, regardless of insurance.	Ongoing	Early Childhood Comprehensive System Staff, Health workgroup team, Nevada Covering Kids and Families, Every Child Matters	Documentation of media and presentations

Result 4: All Infants and young children are socially and emotionally healthy.			
Outcome 4A: By September 2009, Nevada will develop a common vision and plan for developing an integrated and comprehensive behavioral heath system across agencies			
Outcome Objective/Measure : Performance indicators of SIG			
Activities/Strategies	**By When**	**Who**	**Process Measure**
Nevada Division of Child and Family Services, Children's Behavioral Health team is responsible for the following goals and action steps. (See Appendix C for Child and Adolescent State Infrastructure Grant (SIG) in total.)			
1. Prepare the state consortia to develop a comprehensive and integrated plan.	Timeline of SIG	Nevada Children's Behavioral Health, DCFS. The Statewide Team includes project staff and consultants, key DCFS mental health staff, statewide parent network coordinator and the University of Nevada at Las Vegas (UNLV) program evaluation staff.	Performance indicators of SIG
2. Nevada will strengthen and streamline the interagency coordination and funding mechanism needed to support the developing System of Care.			
3. Nevada will develop the needed service and provider infrastructure to implement the integrated and comprehensive behavioral system.			
4. Nevada will develop the infrastructure to support continuing development of the workforce for the integrated and comprehensive behavioral health system.			
5. Nevada will strengthen the state level infrastructure for performance management and quality improvement effort.			

Parent Education and Family Support

Result 1: Provision of basic needs of families is met so they can parent effectively.

Outcome 1A: Families can readily find out about and access services that meet their basic needs (having sufficient means to maintain housing, food and medical care[82]).

Outcome Objective/Measure *: Process measures*

Activities/Strategies	By When	Who	Process Measure
1. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Spring 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
2. Work with 2-1-1 to ensure they have references for all services helping families to meet their basic needs.	January 2008 and ongoing	ECCS staff & parenting/family support workgroup	When asked bout 2-1-1, parents will state that they were able to acquire the information they needed
3. Assure ECCS representation across councils working to improve information distribution and access to housing, food and medical care for families with young children.	Begin 4/2008 and ongoing	ECCS staff	List of agencies/councils and pertinent involvement
4. Develop measures to determine achievement of this outcome.	Spring 2009	ECCS staff	Measurement tool

Outcome 1B: Improved family support through increased communication and collaboration among public and private (service providers) agencies.

Outcome Objective/measure: *By July 2008, the majority of service providers will report a noticeable increase in communication with other providers from the previous 12 months.*

Activities/Strategies		By When	Who	Process Measure
1	Assure ECCS representation on ECE, MCH and other committees formed to increase efficacy of health care system and access within Nevada.	Dec 2006	ECCS, HSSCO, UWSN	Attend committee meetings
2	Utilize January Partners meeting in D.C. to begin building comprehensive collaboration across all service areas of ECCS and Head Start performance standards.	January 2007 and ongoing	ECCS, HSSCO, State Child Care Admin, NDE	Partners attend meeting and develop ongoing working team
3	Develop and track progress of strategies to increase communication across public and private service providers.	Begin Dec 2007-ongoing	ECCS, HSSCO, MCH	

[82] Taylor, S.S. *Jobs May Not Be Enough for Families' Basic Needs*. Women's E-News. July 30, 2001. Available online at http://www.womensenews.org/article.cfm/dyn/aid/163/context/archive

Result 2: All Nevada parents will have access to quality parenting education.

Outcome 2A: By July 1, 2008 quality parenting education is available to families through comprehensive, high quality, effective parent education programs covering a wide range of topics that are culturally appropriate

***Outcome Objective/Measure**: By July 1, 2009,* increase the number of quality parent education programs available *by 20 percent based on a baseline to be compiled in 2008.*

	Activities/Strategies	By When	Who	Process Measure
1	Conduct thorough research and evaluation to identify all sources currently distributing quality-parenting education in person, on the web or other electronic methods to families in Nevada; and compare those available services to best practice models.	Begin March 2008	Early Childhood Comprehensive System Staff, Taskforce members and the UNR Cooperative Extension	Report of the status of parent education programs
2	Identify gaps in parenting education.	Sept. 08	Children Cabinet and ECCS parenting workgroup	Report
3	Develop a strategy to enhance or expand the current programs so that they are of high quality and meet the needs of parents.	Sept. 08	Early Childhood Comprehensive System Staff, Taskforce members and the University of Nevada Reno Cooperative Extension	Written strategy

Outcome 2B: Families are aware of and have access to quality parenting education.			
Outcome Objective/measure: *Process measures*			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1 Build a public awareness campaign to educate and inform parents on the availability of resources and how they can find it.	Sept. 2008	ECCS Parent workgroup	Parental recognition of statewide public awareness campaign
2 Assist quality parent-education providers by helping plan how to make information about their programs available and increase access for families.	Sept. 2008		Plan developed
Outcome 2C: All parenting education programs are of high quality.			
Outcome Objective/Measures: *By Summer 2010, there will be a statistically significant increase in the number of parents who participate in parenting education programs that rate the parenting education program as being of high quality from a baseline collected in the fall of 2008.*			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Winter 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
2. Work with Nev. Cooperative Extension to research how program-quality of parenting education programs is evaluated in other states or localities.	June 2008	Cooperative Extension and ECCS Parenting workgroup	Completed report
3. Develop strategies for how to evaluate and track quality of parenting education programs.	Summer 2008	ECCS Parent workgroup	Written strategies and plan
4. Develop implementation plan based on strategies to evaluate and track quality of parenting education programs.	Fall 2008		

September 2007- August 2008 Workplan

Leadership Development, Communication and Infrastructure

Result 1. Nevada has the resources and political will to adequately support early childhood programs.			
Outcome 1A: By Summer 2008, a leadership body will be developed that will ensure that state policies support early childhood programs in such a way that early childhood programs are coordinated and have the needed resources to be effective in the state of Nevada.			
Outcome Objective/Measure: *Process measures only.*			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1 Identify key public and private sector organizations throughout the state that can be effective advocates for early childhood issues. These will include both public and private sector representatives.	March 31, 2008	Nevada Public Health Foundation (lead), Task Force members and Health Division staff	List of key persons who accept the responsibility and actively participate
2 Assemble the key representatives to share information, collaborate and advocate for early childhood programs.	April 2008	Nevada Public Health Foundation (lead), Task Force members and Health Division staff	Meeting minutes and list of those attending
3 Review current policy statements, such as NevAEYC policy statements/fact sheets on Full-day Kindergarten, Quality ECE, and Compensation Initiatives and develop new policy statements, as needed, that can be used to build advocacy and support from policymakers on issues related to early childhood issues	Fall of 2007 & ongoing	Nevada Public Health Foundation	Written policy statements. Meeting minutes. Publications.; Group structure i.e., by-laws, formal/informal.

Result 2: All agencies/organizations/programs that serve children age birth to five are aware of and knowledgeable about available data and all other services available to assist young children and their families.			
Outcome 2A: By June 2010, improve data communication between agencies and programs that serve children age birth to five.			
***Outcome Objective/measure*:** By July 2010, 75 percent of state agencies that serve birth to five age children will report having easy access to local data and resources.			
Activities/Strategies	**By When**	**Who**	**Process Measure**
1 Identify data sources containing local data that are currently available.	Spring 2008	Health Division Staff and other state/ community partners	List/report of data sources
2 Map assets/gaps/fiscal monies appropriated.	Spring 2008	Health Division Staff and other state/ community partners	Report to share with MCAHB and other stakeholders

3	Develop a central resource from where all agencies can obtain the most current local data. Provide this data to local programs in a useful and understandable way via ECCS website link and/or other links.	Fall 2008		Documentation of the developed resource and the data it contains
4	Identify and secure funding sources to support the above resource.	June 2009		Documentation of process

EARLY CARE AND EDUCATION

Result 1: Early care and education services and programs are high quality.

Outcome 1A: By July 1, 2009 state and local child care licensing regulations will be strengthened.

***Outcome Objective/Measure**: By July 1, 2009, state and local agencies will work together to develop a proposal to change educational standards so that they are equivalent to those of Head Start http://www.headstartinfo.org/infocenter/ehs_tkit1.htm, the National Association of the Education of Young Children (NAEYC) http://www.naeyc.org/faculty/college.asp, and Caring for Our Children: National Health and Safety Performance Standards http://nrc.uchsc.edu/CFOC/.*

Activities/Strategies	By When	Who	Process Measure
1 Develop a strategy to strengthen regulations at state and local levels to match those of Head Start, the NAEYC (National Association of the Education of Young Children) and the National Health and Safety Performance Standards.	Beginning Fall 2007 and ongoing	Health Division, Office of Early Care and Education, Division of Child and Family Services, Head Start State Collaboration Office, local licensing agencies, licensed child care providers, and other key stakeholders.	Licensing regulations that are moving toward best practices are approved by the appropriate board.

Outcome 1B: Increase standards for educational requirements, skills, compensation and experience of early care and education providers in all settings within the field (e.g., privately owned, non-profit, public pre-k, Head Start, etc.).

***Outcome Objective/Measures**: By July 1, 2009 eighty percent of child care providers will meet educational standards set in Outcome 1A above.*

Activities/Strategies	By When	Who	Process Measure
6. Develop and implement a social marketing campaign to increase parent knowledge about and expectations of quality early care and education so that advocacy efforts and demand for high quality early care and education guidelines/regulations increase throughout Nevada.	Spring 2008	Early Childhood Comprehensive System Staff, Nevada State Welfare and NevAEYC.	Written marketing plan delineating funding partners for campaign

7. Investigate, develop and secure funding streams, which will sustain all efforts.	July 2008 ongoing	Early Childhood Comprehensive System Staff, Nevada State Welfare and NevAEYC.	Evidence of increased funding over time

Outcome 1C: Increase availability of child care services and resources that support/nourish families, inclusive of children who have disabilities and other special needs.

Outcome Objective/Measure: *By July 1, 2009, enrollment in licensed child care settings will increase by at least 10 percent over the number reported in 2006; furthermore, the enrollment of children with disabilities and other special needs in licensed child care settings will increase by at least 10 percent over the number reported in 2006.*

Activities/Strategies	By When	Who	Process Measure
1 Build on already existing referral mechanisms to increase the number of parents who access parent education, family support and children's services via referral by early care and education providers. Create a measure to gauge the increase.	Ongoing	Health and Human Services Staff, Nevada Child Care Resource & Referral Network. 2-1-1, The Children's Cabinet and the Child Care Assistance Division in Las Vegas, Family TIES	Instrument to gauge usage
2 Develop an education/training program for providers that will increase their ability to integrate children with disabilities and other special health care needs (Any Education/training program needs to be tied into the NV Registry and there should be a connection back to ECE requirements discussed earlier).		UNLV's ECE program within the Special Education division of the Education Dept. and Family TIES.	Program plan and/or curriculum(s)

Outcome 1D: Increase child care providers' knowledge of health, developmental and behavioral issues of children by utilizing child care health consultants in partnerships with multi-disciplinary teams.

Outcome Objective/Measures: *By July 1, 2009, child care providers will show a statistically significant increase in their knowledge of health, developmental and behavioral issues.*

Activities/Strategies	By When	Who	Process measure
1 Identify members of multi-disciplinary teams to develop a model for Healthy Child Care Nevada, Child Health Care Consultants.	July 2007	Health Division Staff, Office of Early Care and Education, AHEC of Southern Nevada	Team member's commitment and minutes for meetings
2 Identify strategies to recruit and funding mechanisms to sustain Healthy Child Care Nevada Initiative.	Spring 2008	Health Division Staff, AHEC of Southern Nevada	Described strategies and funding mechanism and any funding agreements
3 Recruit and train Child Care Health Consultants (CCHC).	Summer 2008 ongoing	Health Division Staff, AHEC of Southern Nevada	List of consultants and records of training and certification
4 Educate and inform child care providers of the Child Care Health Consultants' services.	September 2008 ongoing	Health Division staff and local health authority staff	List of providers receiving services

MEDICAL HOME/SOCIAL/EMOTIONAL HEALTH

Rationale: *Good physical and mental health during early childhood is important for achieving the cognitive and social components of school readiness, including the ability to engage in the learning process. Lack of access to health insurance and the associated lack of access to a regular source of high-quality health care are associated with the development of preventable conditions and the deterioration of existing conditions that can lead to long-term learning and behavior problems.*

Result 1: All children have a medical [dental] home* that parents will use.

"A Medical Home is primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." (A Medical Home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care.)

Indictors:

3) **immunization rates**
4) **percentage of children who receive well-baby & child checkups**

Outcome 1A: By July 1, 2009, the number of practitioners that incorporate the "seven medical home" model core components will be equivalent to the national average.

Outcome Objective/Measure: *Same as Outcome*

Activities/Strategies	By When	Who	Process Measure
5. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Spring 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
6. Work with state agency and community organizations to establish standards for a medical home.	Summer 2008		Development of standards in Medicaid and Nevada Check Up MCO program HEDIS measures and P4P program
7. Review and/or create methods to identify and assure medical home access to all children 0-5.	Summer 2008		Identified methodology

Outcome 1B: Medical/health care practitioners are knowledgeable and linked to other child and family resources in their communities.

Outcome Objective/Measure: *By September 1, 2009 medical/health care practitioners will show a statistically significant increase in the number of referrals made to other child and family resources from a baseline collected in Summer of 2008.*

Activities/Strategies	By When	Who	Process Measure
5. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Spring 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings

Outcome 1D: Parents know about and use a medical home.

Outcome Objective/Measures: *By August 2009 t*here will be an increase in medical home usage in Nevada by 20 percent from a baseline collected in the 2008 BRFSS.

	Activities/Strategies	By When	Who	Process Measure
7.	Research the availability of current English and Spanish language materials for parents, which addresses the importance of and methods to find a medical home for their children.	June 2008	Early Childhood Comprehensive System Staff, Healthy Kids EPSDT Parent Support and Education group, ECCS health/social / emotional workgroup including members from the Minority Health Program	Report of findings
8.	Work in collaboration with existing medical workgroups/committees at the state and community level to develop culturally/linguistic appropriate outreach material	June 2008		Appropriate outreach materials
Result 2: Sufficient numbers of high-quality pediatric and/or family care practitioners are in every region of the state to meet children's needs.				
Outcome 2B: Increase reimbursement to health care provider for services to a level that is sufficient to encourage pediatricians/family practice physicians to participate in Medicaid and Nevada Check Up.				
Outcome Objective/Measure: *By July 2009, the number of pediatric/family practitioners participating in Medicaid and Nevada Check Up will increase by at least 20 percent from a baseline established in July 2007.*				
	Activities/Strategies	**By When**	**Who**	**Process Measure**
7.	Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Summer 2007	Early Childhood Comprehensive System Staff and Health workgroup team, Division of Health Care Financing and Policy (DHCFP)	Report of findings
8.	Determine if market rates for reimbursement and/or pediatric charges are already available. If they are not, explore the feasibility of conducting a market rate study through an appropriate agency.	Summer 2008		Report on market rates
9.	Use market rate data to determine whether reimbursement levels of public insurance providers are sufficient to encourage pediatricians to participate in Medicaid and Nevada Check Up.	Fall 2008		Report to Health workgroup
Outcome 3B: Minimize barriers to public and private health care coverage through outreach, simplified rules, and other improvements.				
Outcome Objective/measure: *Process measures*				
Activities/Strategies		**By When**	**Who**	**Process Measure**
5.	Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Summer 2007	Early Childhood Comprehensive System Staff, Health workgroup team,	Report of findings

6. Support outreach organizations, such as "Nevada Covering Kids and Families," which have expertise and experience in outreach to enroll children in Medicaid, Nevada Check Up and other plans. Assist in developing sustainable outreach processes throughout all community stakeholders.	Ongoing	Nevada Covering Kids and Families	Report by Nevada Covering Kids and Families on outreach activities
7. Work with FRC and other social service organizations to facilitate access to heath services (i.e., child care, transportation, translation).	Ongoing	Parent/family support ECCS workgroups	Number of referrals made
8. Advocate for universal access to health care for all children birth to five years old, regardless of insurance.	Ongoing	Early Childhood Comprehensive System Staff, Health workgroup team, Nevada Covering Kids and Families, Every Child Matters	Documentation of media and presentations

Result 4: All Infants and young children are socially and emotionally healthy.

Outcome 4A: By September 2009, Nevada will develop a common vision and plan for developing an integrated and comprehensive behavioral heath system across agencies

Outcome Objective/Measure : Performance indicators of State Infrastructure Grant

Activities/Strategies	By When	Who	Process Measure
Nevada Division of Child and Family Services, Children's Behavioral Health team is responsible for the following goals and action steps. (See Appendix C for Child and Adolescent State Infrastructure Grant (SIG) in total.)			
6. Prepare the state consortia to develop a comprehensive and integrated plan.	Timeline of SIG	Nevada Children's Behavioral Health, DCFS. The Statewide Team includes project staff and consultants, key DCFS mental health staff, statewide parent network coordinator and the University of Nevada at Las Vegas (UNLV) program evaluation staff.	Performance indicators of SIG
7. Nevada will strengthen and streamline the interagency coordination and funding mechanism needed to support the developing System of Care.			
8. Nevada will develop the needed service and provider infrastructure to implement the integrated and comprehensive behavioral system.			
9. Nevada will develop the infrastructure to support continuing development of the workforce for the integrated and comprehensive behavioral health system.			
10. Nevada will strengthen the state level infrastructure for performance management and quality improvement effort.			

Parent Education and Family Support

Result 1: Provision of basic needs of families is met so they can parent effectively.

Outcome 1A: Families can readily find out about and access services that meet their basic needs (having sufficient means to maintain housing, food and medical care[83]).

Outcome Objective/Measure *: Process measures*

Activities/Strategies	By When	Who	Process Measure
5. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Spring 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
6. Work with 2-1-1 to ensure they have references for all services helping families to meet their basic needs.	January 2008 and ongoing	ECCS staff & parenting/family support workgroup	When asked bout 2-1-1, parents will state that they were able to acquire the information they needed
7. Assure ECCS representation across councils working to improve information distribution and access to housing, food and medical care for families with young children.	Begin 4/2008 and ongoing	ECCS staff	List of agencies/councils and pertinent involvement
8. Develop measures to determine achievement of this outcome.	Spring 2009	ECCS staff	Measurement tool

Outcome 1B: Improved family support through increased communication and collaboration among public and private (service providers) agencies.

Outcome Objective/measure: *By July 2008, the majority of service providers will report a noticeable increase in communication with other providers from the previous 12 months.*

Activities/Strategies	By When	Who	Process Measure
1. Develop and track progress of strategies to increase communication across public and private service providers.	Begin Dec 2007-ongoing	ECCS, HSSCO, MCH	Partners attend meeting and develop ongoing working team

[83] Taylor, S.S. *Jobs May Not Be Enough for Families' Basic Needs*. Women's E-News. July 30, 2001. Available online at http://www.womensenews.org/article.cfm/dyn/aid/163/context/archive

Result 2: All Nevada parents will have access to quality parenting education.

Outcome 2A: By July 1, 2009 quality parenting education is available to families through comprehensive, high quality, effective parent education programs covering a wide range of topics that are culturally appropriate

***Outcome Objective/Measure**: By July 1, 2009,* increase the number of quality parent education programs available *by 20 percent based on a baseline to be compiled in 2008.*

Activities/Strategies	By When	Who	Process Measure
1 Conduct thorough research and evaluation to identify all sources currently distributing quality-parenting education in person, on the web or other electronic methods to families in Nevada; and compare those available services to best practice models.	Begin March 2008	Early Childhood Comprehensive System Staff, Taskforce members and the UNR Cooperative Extension	Report of the status of parent education programs
2 Identify gaps in parenting education.	Sept. 08	Children Cabinet and ECCS parenting workgroup	Report
3 Develop a strategy to enhance or expand the current programs so that they are of high quality and meet the needs of parents.	Sept. 08	Early Childhood Comprehensive System Staff, Taskforce members and the UNR Cooperative Extension	Written strategy

Outcome 2B: Families are aware of and have access to quality parenting education.

***Outcome Objective/measure:** Process measures*

Activities/Strategies	By When	Who	Process Measure
1 Build a public awareness campaign to educate and inform parents on the availability of resources and how they can find it.	Sept. 2008	ECCS Parent workgroup	Parental recognition of statewide public awareness campaign
2 Assist quality parent-education providers by helping plan how to make information about their programs available and increase access for families.	Sept. 2008		Plan developed

Outcome 2C: All parenting education programs are of high quality.

***Outcome Objective/Measures:** By Summer 2010, there will be a statistically significant increase in the number of parents who participate in parenting education programs that rate the parenting education program as being of high quality from a baseline collected in the fall of 2008.*

Activities/Strategies	By When	Who	Process Measure
5. Early Childhood Comprehensive System Staff and Health workgroup team will identify who needs to be partners in moving this outcome forward and to review the feasibility of the following activities.	Winter 2008	Early Childhood Comprehensive System Staff and Health workgroup team	Report of findings
6. Work with Nev. Cooperative Extension to research how program-quality of parenting education programs is evaluated in other states or localities.	June 2008	Cooperative Extension and ECCS Parenting workgroup	Completed report

7.	Develop strategies for how to evaluate and track quality of parenting education programs.	Summer 2008	ECCS Parent workgroup	Written strategies and plan
8.	Develop implementation plan based on strategies to evaluate and track quality of parenting education programs.	Fall 2008		

Indicator Set for Nevada's Early Childhood Comprehensive Systems Program

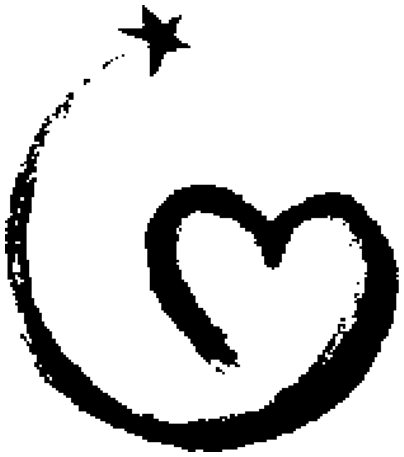
Indicator / Performance Measure

OVERARCHING OUTCOME MEASURES (OOM)				SOURCE OF DATA
OOM	1	Children with reading proficiency in fourth grade as measured by the state's proficiency tests.	Out of the 32,842 children enrolled in 4th grade 41.5% Meets CRT proficiency standards and 16.3% Exceeds standards	SCHOOL DISTRICT ACCOUNTABILITY REPORT 2006-07
POPULATION-BASED RISK MEASURES (PBRM)				**SOURCE OF DATA**
PBRM	1	Children who have multiple risk factors (4 or more demographic risk factors – poverty, parent single and or non English speaking, less than HS education, no employment)	12% of 3,920,613 children aged under 6 years= 470,474 exposed to 3 or more risk factors	NATIONAL CENTER FOR CHILDREN AND POVERTY. REGION IX EARLY CHILDHOOD PROFILE FEB, 2008
PBRM	2	Children birth to six whose racial/ethnic origin is non-white, non-Hispanic.	42,183	US CENSUS BUREAU, CURRENT POPULATION SURVEY, ANNUAL SOCIAL AN ECONOMIC SUPPLEMENT, 2007
PBRM	3	Children birth to six living in extreme poverty (family income at or below 50% of the federal poverty level). Children birth to six living in families with income below the poverty threshold.	20,373	
PBRM	4	Births under 2500 grams (5.5 pounds) □ □ □	2,799 children born with low birth weight out of a total of 35,146 live births	CHDR, NEVADA HEALTH DIVISION. NHIDS, LOW BIRTH WEIGHT MODULE 2004
PBRM	5	Births to teens ages 15-17 per 1,000 girls. □ □ □	26.20 births to 15-17 mothers per 1,000 females aged 15-17	CHDR, NEVADA HEALTH DIVISION. NHIDS, TEEN PREGNANCY MODULE 2004
PBRM	6	Infants born to mothers who receiving late or no prenatal care. □ □	2,073	2007 PRELIMINARY REPORT ON PRENATAL CARE GENERATED BY THE BP&S
HEALTH AND MEDICAL HOME MEASURES (H&M)				**SOURCE OF DATA**
H&M	1	Children under age 6 without health insurance. □ □ □	49,603 CHILDREN 0-5 YEARS OLD, UNINSURED	US CENSUS BUREAU. CURRENT POPULATION SURVEY, ANNUAL SOCIAL AND ECONOMIC SUPPLEMENT, 2007
H&M	2	Children under age 6 with medical homes. □	89,257 CHILDREN AGED 0-<6 HAVE A MEDICAL HOME (46.3%)	The Data Resource Center for Child and Adolescent Health. National Survey of Children's health. MCHAB-HRSA
H&M	3	Percent of toddlers (ages 13 to 36 months) who receive at least one EPSDT periodic screen in a year	N/A	DHP&F is collecting data currently

H&M	4	Young children (ages 19-36 months) who complete the basic series of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. (series 4-3-1-3-3.)	65.40%	PedNSS, 2006 REPORT.US NTIONAL IMMUNIZATION SURVEY
H&M	5	Children ages 2-6 years receiving dental care in the last 12 months.	1,313 among Head Start children (represents 75% of Head Start enrollment)	HEAD START ORAL HEALTH SURVEY, NEVADA 2007
H&M	6	Children ages 2 to five receiving WIC services with a BMI at or above the 85th percentile	16.3% OF CHILDREN 0-5 ARE 85TH PERCENTIL AND 14.0% ARE AT 95TH PERCENTIL	PedNSS, 2006 REPORT. Table 1. State-Specific Prevalence of Selected Nutrition Indicators.
H&M	7	Mothers who breastfeed their infants at 6 months of age. □ □	23.4% of children were breastfed at 6 months age	
H&M	8	Children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 100,000 children less than five years of age.	83.5 per 100,00 children 0-4 years old. (150 discharges/179,563 age group population	CHDR, NEVADA HEALTH DIVISION. NHIDS, HOSPITAL DISCHARGE MODULE 2004
H&M	9	Children under age 6 with blood lead levels at or above 10 micrograms per deciliter.	N/A	SNHD is collecting data for Clark Co.
SPECIAL NEEDS MEASURES (SNM)				**SOURCE OF DATA**
SNM	1	Children birth to 3 years who receive Part C Early Intervention Services.	• FY 07: 2,137 • 3rd Qtr FY 08: 2,432	NEVADA HEALTH DIVISION. BUREAU OF EARLY INTERVENTION SERVICES
SNM	2	Children birth to age three with substantiated cases of abuse and neglect referred to Part C Early Intervention (based on CAPTA).	118 of CAPTA were referred to Part C EIS (represents 19.2%)	CAPTA STATISTICS. BUREAU OF EARLY INTERVENTION SERVICES
SNM	3	Children ages 3-5 enrolled in early childhood Part B Preschools special education programs.		
SNM	4	Children with special health care needs age 0 to 6 who receive coordinated, ongoing, comprehensive care within a medical home.	41.20%	HRSA NATIONAL SURVEY OF CHILDREN WITH SPECIAL HEALTH NEEDS CHARTBOOK 2005-06
SOCIAL-EMOTIONAL DEVELOPMENT AND MENTAL HEALTH MEASURES (S-EDMHS)				**SOURCE OF DATA**
S-EDMHS	1	Substantiated cases of child abuse and neglect among children birth to age 6.	3,423 children 0-7 victims of maltreatment: (Rate: 11.9 per 1,000)	ADMINISTRATION FOR CHILDREN FAMILIES. CHILDREN BUREAU. CHAPTER 3. CHILD MALTREATMENT 2006
S-EDMHS	2	Children birth to age 6 in out-of-home placement (foster care) that had no more than two placements in a 24-month period.	Number of children placed in Foster Care FY 05: a) Entering 3,759; b) Existing 3,149; c) at last day 4,680.	ADMINISTRATION FOR CHILDREN FAMILIES. CHILDREN BUREAU. CHAPTER 3. FOSTER CARE AND ADOPTION 2006
S-EDMHS	3	Children under age 6 who are expelled from child care or preschools due to behavioral problems.	Nevada ranks11th at a rate of 9.48/1000	Expulsion Rates for Prekinderagarten and K-12 by State

EARLY CARE AND EDUCATION MEASURES (ECEM)				SOURCE OF DATA
ECEM	1	Children attending early care and education centers with high quality ratings (slots).	40% of Child Care Centers are rated in High Quality Standards by CERS (No data related to slots)	EVA L. ESSA. UNR. HDFS. THE NEVADA CHILD CARE WORKFORCE STUDY. 2002
ECEM	2	Children ages 3 and 4 years enrolled in a center-based early childhood care and education program (including child care centers, nursery schools, preschool programs, Head start programs, and pre-kindergarten programs).	• 949: State ECE Plan • 2,690 PK School District • Head Start: 2,834 • TOTAL= 6,473	NATIONAL INSTITUTE FOR EARLY EDUCATION RESEARCH. STATE PRESCHOOL YEAR BOOK 2007
ECEM	3	Children under age 6 receiving child care subsidies.	• 3,377 children subsidized attending Center-Based Child Care. • 231 children subsidized attending family home care • 116 children subsidized attending non-licensed family home • TOTAL= 3,724	EVA L. ESSA. UNR. HDFS. THE NEVADA CHILD CARE WORKFORCE STUDY. 2002
ECEM	5	Infants and toddlers (birth to age 3) in poverty who are enrolled in Early Head Start.	3% of 0-3 years old children enrolled in Head Start	NATIONAL INSTITUTE FOR EARLY EDUCATION RESEARCH. STATE PRESCHOOL YEAR BOOK 2007
ECEM	6	Early childhood teachers with a bachelor's degree and specialized training in early childhood.	• Bachelor Degree: 6%; • Associate Degree: 8% • 1Year certificate 9%; • Some College Level 38%	EVA L. ESSA. UNR. HDFS. THE NEVADA CHILD CARE WORKFORCE STUDY. 2002
ECEM	7	Child care centers accredited by the National Association for the Education of Young children (NAECY).	27 accredited by NAECY as 2008	NAEYC ACADEMY FOR EARLY CHILDHOOD PROGRAM ACREDITATION. 2008
ECEM	8	Family child care homes accredited by the National Association for Family and child Care (NAFCC).	NO CHILD CARE HOMES ATTAINED ACCREDITATION (13 Licensed Family Child Care homes are in the process of accreditation)	EVA L. ESSA. UNR. HDFS. THE NEVADA CHILD CARE WORKFORCE STUDY. 2002

Appendix A: CHILD CARE AND DEVELOPMENT FUND PLAN



STATE PLAN FOR CCDF SERVICES

FOR THE PERIOD 10/1/07 – 9/30/09

FOR FY 2008-2009

This Plan describes the CCDF program to be conducted by the state for the period 10/1/07 – 9/30/09. As provided for in the applicable statutes and regulations, the Lead Agency has the flexibility to modify this program at any time, including changing the options selected or described herein.

The official text of the applicable laws and regulations govern, and the Lead Agency acknowledges its responsibility to adhere to them regardless of the fact that, for purposes of simplicity and clarity, the specific provisions printed herein are sometimes paraphrases of, or excerpts and incomplete quotations from, the full text.

Public reporting burden for this collection of information is estimated to average 165 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

(Form ACF 118 Approved OMB Number: 0970-0114 expires [DATE])

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AMENDMENTS LOG

Child Care and Development Services Plan for

For the period: 10/1/07 – 9/30/09

SECTION AMENDED	EFFECTIVE/ PROPOSED EFFECTIVE DATE	DATE SUBMITTED TO ACF	DATE APPROVED BY ACF

Instructions:

1) Lead Agency completes the first 3 columns and sends a photocopy of this Log (showing the latest amendment sent to ACF) and the amended section(s) to the ACF Regional contact. A copy of the Log, showing the latest amendment pending in ACF, is retained in the Lead Agency's Plan.

2) ACF completes column 4 and returns a photocopy of the Log to the grantee.

3) The Lead Agency replaces this page in the Plan with the copy of the Log received from ACF showing the approval date.

Note: This process depends on repeated subsequent use of the same Log page over the life of the Plan. At any time the Log should reflect all amendments, both approved and pending in ACF. The Lead Agency is advised to retain those "old" plan pages that are superseded by amendments in a separate appendix to its Plan.

PART 1

ADMINISTRATION

The agency shown below has been designated by the Chief Executive Officer of the State (or Territory), to represent the State (or Territory) as the Lead Agency. The Lead Agency agrees to administer the program in accordance with applicable Federal laws and regulations and the provisions of this Plan, including the assurances and certifications appended hereto. (658D, 658E)

1.1 Lead Agency Information (as designated by State chief executive officer)

Name of Lead Agency: **Department of Human Resources/Division of Welfare and Supportive Services**

Address of Lead Agency: **1470 College Parkway, Carson City, NV 89706**

Name and Title of the Lead Agency's Chief Executive Officer: **Michael J. Willden, Director**

Phone Number: **(775) 684-4000**
Fax Number: **(775) 684-4010**

E-Mail Address: **nvdhr@dhr.state.nv.us**

Web Address for Lead Agency (if any): **http://welfare.state.nv.us/**

1.2 State Child Care (CCDF) Contact Information (day-to-day contact)

Name of the State Child Care Contact (CCDF): **Gerald J. Allen**

Title of State Child Care Contact: **Chief, Child Care & Development**

Address: **1470 College Parkway, Carson City, NV 89706**

Phone Number: **(775) 684-0630**

Fax Number: **775) 684-0711**

E-Mail Address: : **gallen@dwss.nv.gov**

Phone Number for child care subsidy program information (for the public) (if any):

Southern Nevada: 1-888-387-0090 Northern Nevada: 1-800-753-5500

Web Address for child care subsidy program information (for the public) (if any):

http://welfare.state.nv.us/child care.htm

1.3 Estimated Funding

The Lead Agency estimates that the following amounts will be available for child care services and related activities during the 1-year period: October 1, 2007 through September 30, 2008. (§98.13(a))

CCDF: **$44,485,356.00**

Federal TANF Transfer to CCDF: **$0**

Direct Federal TANF Spending on Child Care: **$0**

State CCDF Maintenance of Effort Funds: **$2,580.421.00**

State Matching Funds: **$11,667,458.00**

Total Funds Available: **$44,485,356.00**

1.4 Estimated Administration Cost

The Lead Agency estimates that the following amount (and percentage) of Federal CCDF and State Matching Funds will be used to administer the program (not to exceed 5 percent): **$ 2,224,267.00 (5 percent).** (658E(c) (3), §§98.13(a), 98.52)

1.5 Administration of the Program

Does the Lead Agency directly administer and implement all services, programs and activities funded under the CCDF Act, including those described in Part 5.1 – Activities & Services to Improve the Quality and Availability of Child Care, Quality Earmarks and Set-Aside?

☐ Yes.

☒ No. If no, use the table below to **identify** the name and type of agency that delivers services and activities. (If the Lead Agency performs the task, mark "n/a" in the box under "Agency." If more than one agency performs the task, identify all agencies in the box under "Agency," and **indicate** in the box to the right whether each is a non-government entity.)

Service/Activity	Agency	Non-Government Entity (see Guidance for definition)	
Determines individual eligibility:			
a) TANF families	University of Nevada Las Vegas	☒ Yes	☐ No
	Children's Cabinet	☐ Yes	☒ No
b) Non-TANF families	University of Nevada Las Vegas	☒ Yes	☐ No
	Children's Cabinet	☐ Yes	☒ No
Assists parents in locating care	University of Nevada Las Vegas	☒ Yes	☐ No
	Children's Cabinet	☐ Yes	☒ No

Makes the provider payment	Children's Cabinet; United Way	☐ Yes	☒ No
Quality activities	University of Nevada Las Vegas	☒ Yes	☐ No
	Children's Cabinet	☐ Yes	☒ No
Other:		☐ Yes	☐ No

If the Lead Agency uses outside agencies to deliver services and activities, **describe** how the Lead Agency maintains overall control.

The Division of Welfare and Supportive Services has direct contracts with non-profit agencies and Interlocal Agreements with other state agencies.

These contracts and agreements allow for ongoing monitoring by the State Child Care Coordinator's office as well as the Quality Control section of the Welfare Division.

1.6 Use of Private Donated Funds

Will the Lead Agency use private funds to meet a part of the matching requirement of the CCDF pursuant to §98.53(e)(2)?

☒ Yes. If yes, are those funds:

☐ Donated directly to the State?

☒ Donated to a separate entity designated to receive private donated funds?

Name: **Nevada Alliance of Boys & Girls Clubs**

Address: **673 S. Stewart Street**

Carson City, NV 89701

Contact: **Kevin McCartney, Senior Director**

Type: **Non-Profit**

☐ No.

1.7 Use of State Pre-Kindergarten (Pre-K) Expenditures for CCDF-Eligible Children

1.7.1 During this plan period, will State expenditures for Pre-K programs be used to meet any of the CCDF maintenance of effort (MOE) requirement?

☐ Yes, and:

( ) The State assures that its level of effort in full day/full year child care services has not been reduced, pursuant to §98.53(h)(1).

(20 percent) Estimated percentage of the MOE requirement that will be met with pre-K expenditures.(Not to exceed 20percent.)

If the State uses Pre-K expenditures to meet more than 10percent of the MOE requirement, the following **describes** how the State will coordinate its Pre-K and child care services to expand the availability of child care (§98.53(h)(4)):

☒ No.

1.7.2 During this plan period, will State expenditures for Pre-K programs be used to meet any of the CCDF Matching Fund requirements? (§98.53(h))

☒ Yes, and

(20percent) Estimated percentage of the Matching Fund requirement that will be met with pre-K expenditures. (Not to exceed 20percent.)

If the State uses Pre-K expenditures to meet more than 10percent of the Matching Fund requirement, the following **describes** how the State will coordinate its Pre-K and child care services to expand the availability of child care (§98.53(h)(4)): **Refer to section 1.7.3**

☐ No.

1.7.3 If the State answered yes to 1.7.1 or 1.7.2, the following **describes** State efforts to ensure that pre-K programs meet the needs of working parents: (§98.53(h)(2))

Additional pre-k services are provided through three state-funded programs: Head Start, Even Start Program, and Nevada Comprehensive Early Childhood Education (Pre-K) Program. Subsidy dollars are used to provide wrap around services. By being able to provide full-day care, parents are able to continue to work full-time. These programs serve low-income families who need

preschool services for their children to be ready to enter kindergarten. The majority of the children served are second language learners. Parents access training and education during early childhood programs. Programs coordinate with child care providers to support working parents if needed.

1.8 Improper Payments

1.8.1 How does the Lead Agency define improper payments?

Any benefit paid to, or on behalf of any individual, household or business that exceeds the amount the individual, household or business was eligible to receive.

1.8.2 Has your State implemented strategies to prevent, measure, identify, reduce and/or collect improper payments? (§98.60(i), §98.65, §98.67)

☒ Yes, and these strategies are:

The Division of Welfare and Supportive Services employs multiple techniques to both deter and identify improper payments. These include, but are not limited to:

- **Management Evaluations – Administrative staff review a sampling of cases to ensure documentation supports case decisions.**
- **Quality Control – Administrative staff review a sampling of cases and perform independent verifications to determine case eligibility.**
- **Supervisory Reviews – In-office program staff review a sampling of cases to ensure case actions are in accordance with policy and the eligibility decision and benefit level is correct.**
- **Investigations – Case investigations are accomplished when staff believe suspicious circumstances exist.**
- **Overpayment Calculations – Staff determine the value of benefits paid versus what should have been paid when initial payment circumstances are determined to be incorrect.**

- **Intentional Program Violations – Administrative disqualification penalties are pursued when it is determined applicants/participants have intentionally violated program rules.**

☐ No. If no, are there plans underway to determine and implement such strategies?

☐ Yes, and these planned strategies are:

☐ No.

PART 2

DEVELOPING THE CHILD CARE PROGRAM

2.1 Consultation and Coordination

2.1.1 Lead Agencies are required to *consult* with appropriate agencies and *coordinate* with other Federal, State, local, tribal (if applicable) and private agencies providing child care and early childhood development services (§98.12, §98.14(a),(b), §98.16(d)). **Indicate** the entities with which the Lead Agency has consulted or coordinated (as defined below), by checking the appropriate box(es) in the following table.

Consultation involves the meeting with or otherwise obtaining input from an appropriate agency in the development of the State Plan. At a minimum, Lead Agencies must consult with representatives of general purpose local governments (noted by the asterisk in the chart below).

Coordination involves the coordination of child care and early childhood development service delivery, including efforts to coordinate across multiple entities, both public and private (for instance, in connection with a State Early Childhood Comprehensive System (SECCS) grant or infant-toddler initiative). At a minimum, Lead Agencies must coordinate with (1) other Federal, State, local, Tribal (if applicable), and/or private agencies responsible for providing child care and early childhood development services, (2) public health (including the agency responsible for immunizations and programs that promote children's emotional and mental health), (3) employment services / workforce development, (4) public education, (5) Temporary Assistance for Needy Families (TANF), and (6) any Indian Tribes in the State receiving CCDF funds (noted by the asterisks in the chart below).

	Consultation in Development of the Plan	**Coordination with Service Delivery**
Other Federal, State, local, Tribal (if applicable), and private agencies providing child care and early childhood development services.	☒	☒ *
Public health	☒	☒ *
Employment services / workforce development	☒	☒ *
Public education	☒	☒ *

	Consultation in Development of the Plan	Coordination with Service Delivery
TANF	☒	☒ *
Indian Tribes/Tribal Organizations, when such entities exist within the boundaries of the State	☒	☒
Representatives of local government	☒ *	☒
State/Tribal agency (agencies) responsible for	☐	☐
State pre-kindergarten programs	☒	☒
Head Start programs	☒	☒
Programs that promote inclusion for children with special needs	☒	☒
Emergency preparedness[o]	☒	☐
Other (See guidance):	☐	☐

* *Required.*

For each box checked above, (a) identify the agency providing the service and (b) describe the consultation and coordination efforts. Descriptions must be provided for any consultation or coordination required by statute or regulation.

[o] If you have prepared an emergency preparedness plan related to your child care and early childhood development services, attach it as **Attachment 2.1.1**.

Consultation in Development of the State Plan – Agencies that have contributed to this plan includes:

Children's Cabinet; Washoe County School District; Head Start Collaboration Office; Bureau of Services for Child Care Licensing; Truckee Meadows Community College; NevAEYC;

Coordination of efforts includes:

- **Participation in the development of the State Early Childhood Comprehensive Systems (SECCS) Grant**
- **Partnership with Head Start State Collaboration Office, Nevada Department of Ed, SECCS Coordinator and Washoe County School District (a recipient of state-funded Pre-K grant and quality set-aside funding to administer several statewide Early Childhood programs including The Nevada Registry and The Child Care Apprenticeship Program) to strategize the**

development of comprehensive governance and finance systems for early childhood in Nevada. Additionally, all of these agency representatives contributed to the development of the ECCS plan and the annual HSSCO work plan.

- **Participation on the United Way of Southern Nevada, Commitment to Education Committee to develop an assessment tool based on Nevada's Pre-K Standards and to improve school readiness outcomes for pre-k children.**
- **Partnership with University of Nevada Reno, campus child care to improve quality of care of home providers through training and accreditation technical assistance**
- **Collaborate with Prevent Child Abuse Nevada in providing training regarding recognizing and reporting child abuse & neglect as well as other health and safety issues**
- **Collaborate with the Nevada Association for the Education of Young Children to locate and secure funding to pilot a WAGES compensation program.**

Nevada does not have an emergency preparedness plan at this time. The Bureau of Services for Child Care Licensing is developing an emergency preparedness plan as a requirement of the Administration for Children and Families Office and will be providing a copy to our office by July 2007.

2.1.2 State Plan for Early Childhood Program Coordination. *Good Start, Grow Smart* encourages States to develop a plan for coordination across early childhood programs. **Indicate** which of the following best describes the current status of the State's efforts in this area. **Note: Check only ONE.**

☒ **Planning**. Indicate whether steps are under way to develop a plan. If so, describe the time frames for completion and/or implementation, the steps anticipated, and how the plan is expected to support early language, literacy, pre-reading and early math concepts.

☐ **Developing**. A plan is being drafted.

The draft is included as **Attachment 2.1.2**.

☐ **Developed**. A plan has been written but has not yet been implemented. The plan is included as **Attachment 2.1.2**.

☐ **Implementing**. A plan has been written and is now in the process of being implemented. The plan is included as **Attachment 2.1.2**.

☐ **Other (describe)**:

Describe the progress made by the State planning for coordination across early childhood programs since the date of submission of the 2006-2007 State Plan.

The Division of Welfare and Supportive Services continues to work with the Health Division, Head Start State Collaboration Office (HSSCO), Department of Education, Head Start and Washoe County School District on the development of the ECCS plan. Once completed and approved, this information will be used in part to complete the Coordination Plan.

Indicate whether there is an entity that is responsible for ensuring that such coordination occurs. Indicate the four or more early childhood programs and/or funding streams that are coordinated and describe the nature of the coordination.

During 2007, the HSSCO received a supplemental grant to facilitate the development of a statewide EC systems team. A group of seven people representing the above mentioned agencies met prior to the national EC systems coordination meeting co-sponsored by the federal Office of Head Start, Maternal Child Health, and Pre-K Now. The team then attended the national meeting where strategies were developed in the areas of governance, finance and provider support. The team continues to meet and has begun coordinating the collection of data across agencies. At this time, the HSSCO continues to provide leadership and funding for the continued process of creating a comprehensive system design that will work for Nevada.

Describe the results or expected results of this coordination. Discuss how these results relate to the development and implementation of the State's early learning guidelines, plans for professional development, and outcomes for children.

Representatives from the Statewide EC System Team participated in developing Nevada's early learning guidelines for pre-kindergarten age children and are currently serving on workgroups to development learning guidelines for infants and toddlers. The HSSCO is in the process of creating a chart/matrix that will identify professional development opportunities and other provider supports available across the state. The HSSCO's 2008 work plan will reflect a focus on exploring and aligning assessments across publicly funded programs in Nevada.

Describe how the State's plan supports or will support continued coordination among the programs. Are changes anticipated in the plan?

The Office of Early Care and Education (OECE) will continue to play an integral part in planning a comprehensive system of early childhood services in Nevada. Each biennium, the state plan is

distributed to key partners for input and review. The HS Reauthorization Act will likely make funding available through HSSCOs for the development of Early Learning Councils. In this event, the OECE will be a key partner in that process. Any changes resulting from the systems planning will be reflected in future child development plans.

2.2 Public Hearing Process

Describe the Statewide public hearing process held to provide the public an opportunity to comment on the provision of child care services under this Plan. (658D(b)(1)(C), §98.14(c)) At a minimum, the description must provide:

Date(s) of statewide notice of public hearing: **April 27, 2007**

Manner of notifying the public about the statewide hearing:

The 30-Day Public Notice is posted at various locations statewide and mailed to those on the mailing list pursuant to Nevada Revised Statute (NRS) 241.020.

Testimony and written materials submitted during the public hearing will be considered. Persons wishing to comment on the Child Care State Plan, amendments and/or regulations and policy changes on the agenda may appear at the scheduled public hearing or address their comments in writing to: Welfare Division Administrator, 1470 College Parkway, Carson City, Nevada 89706. Written submissions should be received by June 13, 2007 to be given adequate time for copying and consideration at the hearing. Persons wishing to comment may also appear at the public hearing on June 22, 2007.

Persons with disabilities who require special accommodations or assistance at the meeting are requested to notify the Nevada State Welfare Division no later than five (5) working days before the public hearing.

Date(s) of public hearing(s): **June 20, 2007**

Hearing site(s): **Via videoconference at the following locations:**

Dept. of Business and Industry
Hearing Room
788 Fairview Dr
Carson City, Nevada

Dept. Of Business and Industry
Second Floor Conference Room
2501 E. Sahara Ave.
Las Vegas, Nevada

How the content of the plan was made available to the public in advance of the public hearing(s):

The public hearing agenda and exhibits, including the proposed Child Care State Plan, are published on the Division of Welfare and Supportive Services' website, posted at various locations statewide, and mailed upon request.

A brief summary of the public comments from this process is included as **Attachment 2.2**. **N/A**

2.3 Public-Private Partnerships

Does the Lead Agency conduct or plan to conduct activities to encourage public-private partnerships that promote private-sector involvement in meeting child care needs?

☒ Yes. If yes, **describe** these activities or planned activities, including the results or expected results.

Monthly and quarterly meetings of the Quality, Training, and Licensing Subcommittee and the Child Care Advisory Committee continue to provide an avenue for public-private partnerships in meeting child care needs.

Sponsorship of the Nevada Association for the Education of Young Children Early Childhood Conference.

Input is requested from public-private partnerships in areas of quality improvement. The most recent issue presented in October 2006 was a possible change in Nevada's career ladder.

The Child Care Resource and Referral agencies provide special community programs that promote quality such as:

- **Continuity of care for children with special needs through the use of behavior specialist interns.**
- **City Parks and Recreation receipt of quality dollars to provide continuity of care for children**
- **Provision of CPR vouchers for Early Childhood providers.**
- **Use of contracted slots with recreation programs to stabilize funding and ensure availability of child care placements.**

- **The goal for 2007-09 is to develop additional new relationships and enhance the existing partnerships between the public and private sectors. This will lead to increased coordination of quality child care services for children and opportunities for full day, full year services to families.**

☐ No.

PART 3

CHILD CARE SERVICES OFFERED

3.1 Description of Child Care Services

3.1.1 Certificate Payment System

Describe the overall child care certificate process, including, at a minimum:

(1) a description of the form of the certificate (98.16(k));

(2) a description of how the certificate program permits parents to choose from a variety of child care settings by explaining how a parent moves from receipt of the certificate to choice of the provider; (658E(c)(2)(A)(iii), 658P(2), 98.2, 98.30(c)(4) & (e)(1) & (2)) and

(3) if the Lead Agency is also providing child care services through grants and contracts, estimate the proportion of §98.50 services available through certificates versus grants/contracts, and explain how it ensures that parents offered child care services are given the option of receiving a child care certificate. (98.30(a) & (b)) This may be expressed in terms of dollars, number of slots, or percentages of services.

A computer-generated certificate is issued to the parent after a child care eligibility worker has entered all of the required data. The certificate includes: the amount the program will pay to the provider; the time frame for which the certificate is valid; the name of the provider chosen by the parent; information about the parent; the funding source; the name of the parent's case manager; the child's vital information; the approved child care schedule; the daily rate; and a place for the parent's signature.

Parents may choose any eligible provider. If the parent needs assistance in choosing a provider they may request assistance from the child care contractor staff, who can provide a listing of available child care options to the parent. Once the parent has chosen a provider, the provider's name and address is entered into the computer and automatically printed out on the certificate.

The Lead Agency contracts with one Resource and Referral (R&R) agency to operate the Child Care Subsidy Program. The agency contracts with local governmental and non-governmental agencies that operate before and after-school programs. Parents of children in such programs who want another type of child care are advised to apply with the R&R agency, and they will be issued a certificate with their choice of provider. Approximately

76percent of all child care is processed through certificates and approximately 24percent through contracts for slots.

Attach a copy of your eligibility worker's manual, policy handbook, or other printed guidelines for administering the child care subsidy program as **Attachment 3.1.1.** If these materials are available on the web, the State may provide the appropriate Web site address in lieu of attaching hard copies to the Plan.

The manual is located on the DWSS website: http://www.welfare.state.nv.us/child_care/ccm.htm

Note: Eligibility worker's manuals, policy handbooks, or other printed guidelines for administering a child care subsidy program will be used for reference purposes only. Documents provided by Lead Agencies pursuant to this section will not be uniformly or comprehensively reviewed and will not be considered part of the Plan. All information required to be part of the Plan must continue to be set forth in the Plan.

3.1.2 In addition to offering certificates, does the Lead Agency also have grants or contracts for child care slots?

☒ Yes, and the following **describes** the types of child care services, the process for accessing grants or contracts, and the range of providers that will be available through grants or contracts: (658A(b)(1), 658P(4), §§98.16(g)(1), 98.30(a)(1) & (b))

The Division of Welfare and Supportive Services through its contractors contracts with various city and county programs to provide before and after-school services to low income families.

☐ No.

3.1.3 The Lead Agency must allow for in-home care but may limit its use. Does the Lead Agency limit the use of in-home care in any way?

☒ Yes, and the limits and the reasons for those limits are: (§§98.16(g)(2), 98.30(e)(1)(iv))

Payment for child care services to a provider who resides in the same residence as the child is not allowed, unless the child is verified to have a special need as defined in the policy manual.

In addition, to ensure providers who perform services in the child's home meet the minimum wage requirement, they must care for a minimum of two (2) subsidized children to be eligible for reimbursement.

☐ No.

3.1.4 Are child care services provided through certificates, grants and/or contracts offered throughout the State? (658E(a), §98.16(g)(3))

☒ Yes.

☐ No, and the following are the localities (political subdivisions) and the services that are not offered:

3.2 Payment Rates for the Provision of Child Care

The statute at 658E(c)(4) and the regulations at §98.43(b)(1) require the Lead Agency to establish payment rates for child care services that ensure eligible children equal access to comparable care.

These rates are provided as **Attachment 3.2A**.

The attached payment rates were or will be effective as of **November 1, 2004**.

Provide a summary of the facts relied on by the State to determine that the attached rates are sufficient to ensure equal access to comparable child care services provided to children whose parents are not eligible to receive child care assistance under the CCDF and other governmental programs. Include, at a minimum:

- The month and year when the local market rate survey(s) was completed: **December 2006** . (§98.43(b)(2))

- A copy of the **Market Rate Survey instrument** and a **summary of the results** of the survey are provided as **Attachment 3.2B**. At a minimum, this summary should include a description of the sample population, data source, the type of methodology used, response rate, description of analyses, and key findings (**See Guidance for additional information.)**

The 2 non-profit agencies (The Children's Cabinet and EOB) sent out questionnaires to all of the providers within their counties. Northern Nevada sent out a total of 336 surveys, to licensed providers, licensed family day homes and before and after school programs. They received 292 responses for return rate of 87percent. Southern Nevada sent out 499 surveys to licensed providers, licensed family

day home and before and after school programs. They received 156 responses for a return rate of 31percent.

- Does the Lead Agency use its **current** Market Rate Survey (a survey completed within the allowable time period –10/1/05 -9/30/07) to set payment rates?

☐ Yes.

☒ No.

At what percentile of the current Market Rate Survey is the State rate ceiling set? If you do not use your current Market Rate Survey to set your rate ceilings or your percentile varies across categories of care (e.g., type of setting, region, age of children), describe and provide the range of variation in relation to your current survey. **(See Guidance for additional information.)**

The Division of Welfare and Supportive Services developed rates to ensure adequate compensation to child care providers and offered incentive to provide infant and toddler services, therefore Nevada's rates vary across the categories of care. However the statewide averages per category are:

Infant – 85percent

Toddler – 74percent

Pre-School – 74percent

School Age – 73percent

Our rates, which were set using the 2004 Market Rate Survey, have not been adjusted since. The rates are determined by:

County (Clark, Washoe, Carson/Douglas and Rural);

Provider type (licensed center, licensed group, licensed family home, informal care and before and after school unlicensed care); and

Age (infant, toddler, preschool and school age)

- How the payment rates are adequate to ensure equal access to the full range of providers based on the results of the above noted local market rate survey (i.e., describe the relationship between the attached payment rates and the market rates observed in the survey): (§98.43(b)) **N/A**

- Does the Lead Agency consider any additional facts to determine that its payment rates ensure equal access? (§98.43(d))

  ☒ Yes. If, yes, **describe**.

  Nevada's rates are established based upon four geographic regions and are further defined by provider type and the child's age. This ensures the prevailing market rates for a particular geographic area are considered.

  ☐ No.

- Does the State have a tiered reimbursement system (higher rates for child care centers and family child care homes that achieve one or more levels of quality beyond basic licensing requirements)?

  ☒ Yes. If yes, **describe**:

  Nevada has approved and is implementing a 4 level Tiered Reimbursement system. Level 1 is the Licensed level. Level 4 is the accredited level. Levels 2 and 3 are designed but not yet implemented due to the lack of staff necessary to evaluate and monitor each provider's status.

  ☐ No.

3.3 Eligibility Criteria for Child Care

3.3.1 Age Eligibility

Does the Lead Agency allow CCDF-funded child care for children above age 13 but below age 19 who are physically and/or mentally incapable of self-care? (Physical and mental incapacity must then be defined in Appendix 2.) (658E(c)(3)(B), 658P(*3*), §98.20(a)(1)(ii))

☒ Yes, and the upper age is **18**.

☐ No.

Does the Lead Agency allow CCDF-funded child care for children above age 13 but below age 19 who are under court supervision? (658P(3), 658E(c)(3)(B), §98.20(a)(1)(ii))

☐ Yes, and the upper age is ___.

☒ No.

3.3.2 Income Eligibility

Complete columns (a) and (b) in the matrix below. Complete Columns (c) and (d) ONLY IF the Lead Agency is using income eligibility limits lower than 85percent of the SMI.

			IF APPLICABLE	
Family Size	**(a)** **100percent of State Median Income (SMI)** **($/month)**	**(b)** **85percent of State Median Income (SMI)** **($/month)** **[Multiply (a) by 0.85]**	**Income Level, lower than 85percent SMI, if used to limit eligibility**	
			(c) **$/month**	**(d)** **percent of SMI** [Divide (c) by (a), multiply by 100]
1	**$2,677**	**$2,275**	**$2,008**	**75**
2	**$3,501**	**$2,976**	**$2,626**	**75**
3	**$4,324**	**$3,675**	**$3,243**	**75**
4	**$5,148**	**$4,376**	**$3,861**	**75**
5	**$5,972**	**$5,076**	**$4,479**	**75**

If the Lead Agency does not use the SMI from the most current year, **indicate** the year used:

If applicable, indicate the date on which the eligibility limits detailed in column (c) became or will become effective: **October 1, 2007**

How does the Lead Agency define "income" for the purposes of eligibility? Describe and/or include information as **Attachment 3.3.2**. (§§98.16(g)(5), 98.20(b))

Income is defined as any type of payment which is a gain or benefit to a household.

- Is any income deducted or excluded from total family income (for instance, work or medical expenses; child support paid to, or received from, other households; Supplemental Security Income (SSI) payments)?

☒ Yes. If yes, **describe** what type of income is deducted or excluded from total family income.

An Average Cost of Care deduction is allowed when a parent/caretaker is caring for a relative child and receiving a TANF grant as a Non-needy Caretaker, Kinship Care household.

Deduction for a repayment of an overpayment/wage advance to the same entity issuing the ongoing check

The deduction allowance for the amount of Drug Addiction and Alcohol (DAA) Social Security Disability Income (SSDI) fee collected by the authorized representative payee

Excluded Income:

Crime Victim's Compensation Payments

Earned Income Tax Credit (EITC)

Educational Assistance and Work Study Income

Gift Certificates

Subsidized Housing Assistance

Job Training and Training Allowances

Loans

Native and Indian Claims

Radiation Exposure Compensation Act Payments

Relocation Assistance

Supplemental Security Income (SSI)

Vendor Payments

Victims of Nazi Persecution Payments

☐ No.

- Is the income of all family members included?

☐ Yes.

☒ No. If no, **describe** whose income is excluded for purposes of eligibility determination.

The income of a sibling age 18 or younger who is attending high school.

The income of foster parents only if they are licensed under the Foster Care Program.

3.3.3 Eligibility Based Upon Receiving or Needing to Receive Protective Services

Does the State choose to provide child care to children in protective services, as defined in Appendix 2? (§§98.16(f)(7), 98.20(a)(3)(ii)(A) & (B))

☒ Yes.

☐ No.

Has the Lead Agency elected to waive, on a case-by-case basis, the fee and income eligibility requirements for cases in which children receive, or need to receive, protective services, as defined in Appendix 2? (658E(c)(3)(B), 658P(3)(C)(ii), §98.20(a)(3)(ii)(A))

☒ Yes.

☐ No.

☐ Not applicable. CCDF-funded child care is not provided in cases in which children receive, or need to receive, protective services.

Does the State choose to provide CCDF-funded child care to children in foster care whose foster care parents are <u>not</u> working, or who are <u>not</u> in education/training activities? (§§98.20(a)(3)(ii), 98.16(f)(7))

☐ Yes. (**NOTE**: This means that for CCDF purposes the State considers these children to be in protective services.)

☒ No.

3.3.4 Additional Eligibility Conditions

Has the Lead Agency established additional eligibility conditions? (658E(c)(3)(B), §98.16(g)(5), §98.20(b))

☐ Yes, and the addition-l eligibility conditions are: (Terms must be defined in Appendix 2)

☒ No.

3.4 Priorities for Serving Children and Families

3.4.1 Complete the table below regarding eligibility conditions and priority rules. For columns (a) through (d), check box if reply is "Yes". Leave blank if "No". Complete column (e) if you check column (d).

Eligibility Category	(a) Guarantee subsidy eligibility	(b) Give priority over other CCDF-eligible families	(c) Same priority as other CCDF-eligible families	(d) Is there a time limit on guarantee or priority?	(e) How long is time limit?
Children with special needs	☐	☒	☐	☐	
Children in families with very low incomes	☐	☐	☒	☐	
Families receiving Temporary Assistance for Needy Families (TANF)	☒	☒	☐	☐	
Families transitioning from TANF	☐	☐	☒	☐	
Families at risk of becoming dependent on TANF	☐	☒	☐	☐	

3.4.2 **Describe** how the State prioritizes service for the following CCDF-eligible children: (a) children with special needs and (b) children in families with very low incomes. Terms must be defined in Appendix 2. (658E(c)(3)(B))

The highest priority for receiving child care subsidies are those families who are unemployed and pending TANF assistance or families receiving TANF cash assistance. These families are considered "mandatory families" or families that must be served.

The second highest priority for receiving child care subsidies are families with special needs child(ren) whose income is at or below 130percent of the Federal Poverty Level based upon the household size.

The third highest priority for receiving child care subsidies are those families who are "at-risk" of needing TANF cash assistance with incomes at or below 130percent of the Federal Poverty Level based on the household size.

The fourth highest priority for receiving child care subsidies are families with special needs child(ren) whose income is above 130percent of the Federal Poverty Level and at or below 75percent of the State's median income.

The fifth highest priority for receiving child care subsidies are those families with incomes above 130percent of the Federal Poverty Level and below 75percent of the State's median income.

3.4.3 **Describe** how CCDF funds will be used to meet the needs of: (a) families receiving Temporary Assistance for Needy Families (TANF), (b) those attempting to transition off TANF through work activities, and (c) those at risk of becoming dependent on TANF. (658E(c)(2)(H), Section 418(b)(2) of the Social Security Act, §§98.50(e), 98.16(g)(4))

Individuals applying for TANF cash assistance must participate in pre-eligibility work activities based upon a comprehensive assessment of the individual's work history, employment goals and barriers to obtaining and maintaining employment. These pre-eligibility work activities can include trainings, orientations, job readiness programs, job search or any other activity deemed necessary for the individual to obtain/maintain employment. While the individual is participating in a pre-eligibility work activity, the State will pay up to 100percent of the state maximum for the household's child care needs as long as the household's countable income is at or below the poverty level.

If the individual does not find employment and begins receiving TANF cash assistance and participates in a TANF work-related activity through the New Employees of Nevada (NEON) program, the Division of Welfare and Supportive Services will pay up to

100percent of the state maximum of the household's child care needs while the individual is participating in a work or training activity. This status is referred to as New Employees of Nevada (NEON).

If the individual has transitioned off TANF and has purpose of care (i.e. working, training, educational classes, etc.) and the household's income is at or below 130percent of the Federal Poverty Level, this household would be considered "at-risk" and would be the third highest priority (see 3.4.1)

If the household's income is above 130percent of the Federal Poverty Level, but below the State's 75percent median income, the household may receive subsidy benefits from the "discretionary" funding category and is considered the fifth highest priority (see 3.4.1).

3.4.4 Has the Lead Agency established additional priority rules that are not reflected in the table completed for Section 3.4.1? (658E(c)(3)(B), §98.16(g)(5), §98.20(b))

☐ Yes, and the additional priority rules are: (Terms must be defined in Appendix 2)

☒ No.

3.4.5 Does the Lead Agency serve all eligible families that apply?

☒ Yes.

☐ No.

3.4.6 Does the Lead Agency maintain a waiting list?

☐ Yes. If yes, for what populations? Is the waiting list maintained at the State level? Are certain populations given priority for services, and if so, which populations? What methods are employed to keep the list current?

☒ No.

3.5 Sliding Fee Scale for Child Care Services

3.5.1 A sliding fee scale, which is used to determine each family's contribution to the cost of child care, must vary based on income and the size of the family. A copy of this sliding fee scale for child care services and an explanation of how it works is provided as **Attachment 3.5.1**.

The attached fee scale was or will be effective as of **October 2007**.

Will the Lead Agency use additional factors to determine each family's contribution to the cost of child care? (658E(c)(3)(B), §98.42(b))

☐ Yes, and the following **describes** any additional factors that will be used:

☒ No.

3.5.2 Is the sliding fee scale provided in the attachment in response to question 3.5.1 used in all parts of the State? (658E(c)(3)(B))

☒ Yes.

☐ No, and other scale(s) and their effective date(s) are provided as **Attachment 3.5.2**.

3.5.3 The Lead Agency may waive contributions from families whose incomes are at or below the poverty level for a family of the same size, (§98.42(c)), and the poverty level used by the Lead Agency for a family of 3 is: **$ 1,431.00**. **(HHS 2007 Poverty Guidelines)**.

The Lead Agency must **select ONE** of these options:

☐ ALL families with income at or below the poverty level for a family of the same size ARE NOT required to pay a fee.

☐ ALL families, including those with incomes at or below the poverty level for families of the same size, ARE required to pay a fee.

☒ SOME families with income at or below the poverty level for a family of the same size ARE NOT required to pay a fee. The following describes these families:

The following households may receive 100percent subsidy:

- **Families who are pending TANF cash assistance and participating in pre-eligibility work activities; or**
- **Families pending TANF cash assistance and at the time of TANF application they were unemployed but found employment during the TANF pending period; or**
- **Families who are receiving TANF cash assistance and participating in a TANF work-related activity through the New Employees of Nevada (NEON) program; or**
- **Foster parents, as long as all other eligibility requirements are met (i.e. purpose of care, etc.); or**
- **Child Protective Services (CPS) has placed the child in the household and the caretaker is not related by blood or marriage.**

3.5.4 Does the State allow providers to charge parents the difference between the maximum reimbursement rate and their private pay rate?

☒ Yes.

☐ No.

3.5.5 The following is an explanation of how the copayments required by the Lead Agency's sliding fee scale(s) were determined to be affordable: (§98.43(b)(3))

All families who participate in the child care subsidy program must make a minimum co-payment of 5percent, unless they meet one of the exceptions listed in section 3.5.3.

A family's average co-payment is approximately 6.8percent. (Source: Family Profile data from the December 2006 Federal 801 monthly report).

PART 4

PARENTAL RIGHTS AND RESPONSIBILITIES

4.1 Application Process / Parental Choice

4.1.1 **Describe** the process for a family to apply for and receive child care services (658D(b)(1)(A), 658E(c)(2)(D) & (3)(B), §§98.16(k), 98.30(a) through (e)). At minimum, the description should include:

- How parents are informed of the availability of child care services and about child care options
- Where/how applications are made
- What documentation parents must provide
- How parents who receive TANF benefits are informed about the exception to individual penalties as described in 4.4
- Length of eligibility period including variations that relate to the services provided, e.g., through collaborations with Head Start or pre-kindergarten programs
- Any steps the State has taken to reduce barriers to initial and continuing eligibility for child care subsidies

Parents are informed of the availability of child care services in a variety of ways. The print media is used as well as television and radio. Representatives of The Children's Cabinet in northern Nevada are regularly interviewed on television.

Applications for child care services can be made at any of the Welfare District offices, the contractor's main offices, or through the mail.

Child care eligibility staff determine the eligibility for child care subsidy benefits based on proof of income, purpose of care, etc. All child care eligibility determinations are not to exceed six (6) months. Please refer to section 4.4 concerning "Work Requirement Exception".

The Early Head Start programs determine a family's eligibility when the child enters the program. The child care program providing wrap-around funding accepts that determination. A family's

eligibility is not re-determined until that child enters Head Start. The Child Care Program providing wrap-around funding accepts that determination. Once the child leaves Head Start and enters regular child care through the subsidy program, the family's eligibility is re-determined every six (6) months minimum.

In the case where a certain number of slots are purchased through a contract, as in before-and-after school programs, the family's eligibility is determined upon entering the program and annually thereafter.

Attach a copy of your parent application for the child care subsidy program. If the application is available on the web, provide the appropriate Web site address (application must still be attached to Plan):

4.1.2 Is the application process different for families receiving TANF?

☐ Yes. If yes, **describe** how the process is different:

☒ No.

4.1.3 The following is a detailed description of how the State ensures parental choice by making sure that parents are informed about their ability to choose from among family and group home care, center-based care and in-home care including faith-based providers in each of these categories.

The Child Care and Development Program and the Children's Cabinet maintain resource and referral capabilities to provide parents with a full range of child care options, including faith based programs.

4.1.4 Does the State conduct activities aimed at families with limited English proficiency to promote access to child care subsidies and reduce barriers to receiving subsidies and accessing child care services?

☒ Yes. If yes, **describe** these activities, including how the State overcomes language barriers with families and providers.

- **Child Development Associate classes are offered in Spanish.**
- **All child care materials, ie, informational pamphlets, applications, etc. are printed in Spanish.**
- **Interviews and articles are submitted to a local Spanish language newspaper, "Ahora", interviews on the local Spanish language radio station, Radio Tri-Color.**
- **Identified local businesses are sent newsletters, brochures and other literature regarding subsidy, quality child care, finding child care, parenting tips etc. written in Spanish and free to the public.**

- **Efforts to reduce barriers include Spanish speaking employees, contracted translation services, (for all languages), all program paperwork available in Spanish, and registration of Spanish speaking child care providers**

☐ No.

4.2 Records of Parental Complaints

The following is a detailed description of how the State maintains a record of substantiated parental complaints and how it makes the information regarding such parental complaints available to the public on request. (658E(c)(2)(C), §98.32))

The Lead Agency or contract agency records the complaint on a complaint form and forwards it to the appropriate regulatory agency within twenty-four (24) hours after receipt.

A copy of the substantiated complaint and its subsequent resolution is available to the public upon request through the regulatory agency.

4.3 Unlimited Access to Children in Child Care Settings

The following is a detailed description of the procedures in effect in the State for affording parents unlimited access to their children whenever their children are in the care of a provider who receives CCDF funds. (658E(c)(2)(B), §98.31))

All providers are initially notified that parents are to be afforded unrestricted access to their children whenever their children are in the care of the provider. Upon receipt of information that a particular provider is not following this policy, the provider is notified that they must either allow the parent(s) immediate and unlimited access or they will be dropped from the program pursuant to Nevada Administrative Code (NAC) 432A.350(i).

NAC 432A.350(i) gives either or both parents the right to observe the program of the licensee before enrollment and at any time after enrollment of the child.

4.4 Criteria or Definitions Applied by TANF Agency to Determine Inability to Obtain Child Care

The regulations at §98.33(b) require the Lead Agency to inform parents who receive TANF benefits about the exception to the individual penalties associated with the work requirement for any single custodial parent who has a demonstrated inability to obtain needed child care for a child under 6 years of age.

In fulfilling this requirement, the following criteria or definitions are applied by the TANF agency to determine whether the parent has a demonstrated inability to obtain needed child care:

The Division of Welfare and Supportive Services administers both TANF and Child Care programs. TANF and child care staff are co-located in each Welfare District office. Child care staff have a "Work Requirement Exception" form (2153-WC) that is completed, signed and sent by a child care eligibility worker to the Welfare eligibility worker when a single custodial parent cannot find appropriate child care that is within a reasonable distance and affordable. The Welfare eligibility worker will

either concur and sign the work exception requirement or change the activity to accommodate the recipient.

NOTE: The TANF agency, not the Child Care Lead Agency, is responsible for establishing the following criteria or definitions. These criteria or definitions are offered in this Plan as a matter of public record. The TANF agency that established these criteria or definitions is: **The Division of Welfare and Supportive Services** .

- "appropriate child care":

  Child care chosen by the parent that offers developmentally appropriate practices that meet the needs of that parent and child.

- "reasonable distance":

  A parent should not have to travel more than 60 minutes to drop-off or pick-up their child from the child care provider's location.

- "unsuitability of informal child care":

  Informal child care is unsuitable if it is not provided legally, or does not meet basic health and safety standards as outlined in the State Child Care Plan.

  Informal child care is unsuitable if circumstances exist that may cause possible abuse, neglect or harm to children as outlined in county ordinances and/or state statutes.

  Informal child care is unsuitable if: the arrangements do not support the working schedule of a parent; are not affordable; not easily accessible; or do not meet quality standards as defined by the parent.

- "affordable child care arrangements":

  Affordable child care is child care that does not exceed 10percent of the parent's gross income.

PART 5

ACTIVITIES & SERVICES TO IMPROVE THE QUALITY AND AVAILABILITY OF CHILD CARE

5.1 Quality Earmarks and Set-Asides

5.1.1 The Child Care and Development Fund provides earmarks for infant and toddler care and school-age care and resource and referral services as well as the special earmark for quality activities. The following describes the activities; identifies the entities providing the activities; describes the expected results of the activities and, if the activities have been ongoing, the actual results of the activities. **For the infant and toddler earmark, the State must note in its description of the activities what is the maximum age of a child who may be served with such earmarked funds (not to exceed 36 months).**

Infants and toddlers:

Nevada Early Intervention Services (NEIS)-Rural Services (State Agency)

- **Provide speech consultation, screenings, assessments, training, and transition services to parents, child care centers, Early Head Start centers, and others of developmentally delayed infants and toddlers.**

- **Child Find presentations to child care centers, Early Head Start Centers and others to include underserved areas or populations in rural NV to inform about services provided by NEIS.**

Nevada Early Intervention Services (State Agency)

- **Train child care providers to include children with special needs.**

- **Develop site-specific quality improvement plans for 10 sites. Assist sites in obtaining needed materials and equipment to improve the quality of their child care programs. Place 10 Part C eligible children in child care settings to receive their early intervention services.**

NV Office of Early Care and Education (State Agency)

- **Provide a resource library for child care providers in Southern NV that includes developmental books, activity books, toys, and children's books specific to the care and education of infants and toddlers.**

NevAEYC (Non-Profit Community Agency)

- **T.E.A.C.H. Early Childhood® Nevada is a comprehensive scholarship program designed to assist child care providers in obtaining an associates degree in early childhood with a specialization in infant/toddler care and education.**

Child Care and Development Program/Children's Cabinet (Child Care Resource and Referral)

- **Provide Early Head Start wrap-around services.**
- **Provide mini-grants for the improvement of infant/toddler environments and expansion of infant/toddler slots in licensed child care settings.**

Resource and referral services:

Child Care and Development Program/Children's Cabinet (Child Care Resource and Referral)

- **Assist families by providing referrals to licensed child care providers that best meet the needs of the family and provide comprehensive consumer education on quality child care so parents can make informed child care choices.**

School-age child care:

Children's Cabinet (Child Care Resource and Referral)

- **City of Reno Parks and Recreation program operates inclusive after school child care settings and receives funding to provide behavior management assistance and staff training on issues related to special needs children. The goal of the program is to support the continuity of care for school age**

children, prevent expulsion form after school programs and increase the knowledge and skill of staff.

- **Resources and information for school age child care are distributed through quarterly newsletters to parents and providers and through monthly child care "Tip Sheets" to providers. In addition, identified businesses throughout the state receive regular supplies of quality child care publications, brochures on services and newsletters which are made available to the public.**

Office of Early Care and Education (State Agency)

- **Through the accreditation facilitation project, the City of Reno Parks and Recreation programs are in the process of accreditation through the National After-School Association (NAA).**

5.1.2 The law requires that not less than 4percent of the CCDF be set aside for quality activities. (658E(c)(3)(B), 658G, §§98.13(a), 98.16(h), 98.51) The Lead Agency estimates that the following amount and percentage will be used for the quality activities (not including earmarked funds) during the 1-year period: October 1, 2007 through September 30, 2008:

$2,333,492.00 (6percent)

5.1.3 **Check** each activity the Lead Agency will undertake to improve the availability and quality of child care (include activities funded through the 4percent quality set-aside as well as the special earmark for quality activities). (658D(b)(1)(D), 658E(c)(3)(B), §§98.13(a), 98.16(h))

Activity	Check if undertaking/will undertake	Name and type of entity providing activity	Check if this entity is a non-governmental entity?
Comprehensive consumer education	☒	**Children's Cabinet (Resource and Referral Agency)** **Child Care and Development Program** **(State Agency)**	☒
Grants or loans to providers to assist in meeting State and local standards	☒	**Children's Cabinet (Resource and Referral Agency)**	☒
Monitoring compliance with licensing and regulatory requirements	☒	**Bureau of Services for Child Care Licensing (State Agency)**	☐
Professional development, including training, education, and technical assistance	☒	**Office of Early Care and Education (State Agency)** **Children's Cabinet (Resource and Referral Agency)** **Child Care and Development Program**	☒

		(State Agency)	
Improving salaries and other compensation for child care providers	☒	**Washoe County School District (School Dist)** **NevAEYC (Non-profit)**	☒
Activities in support of early language, literacy, pre-reading, and early math concepts development	☒	**Washoe County School District (School Dist)**	☐
Activities to promote inclusive child care	☒	**Office of Early Care and Education (State Agency)**	☐
Healthy Child Care America and other health activities including those designed to promote the social and emotional development of children	☐		☐
Activities that increase parental choice	☒	**Children's Cabinet (Resource and Referral Agency)** **Child Care and Development Program** **(State Agency)**	☒
Other activities that improve the quality of child care (describe below).	☒	**Washoe County School District (School Dist)** **Office of Early Care and Education (State Agency)**	☐

Other activities that improve the availability of child care (describe below). (§98.51(a)(1) and (2))	☐		☐

5.1.4 For each activity checked, **describe** the expected results of the activity. If you have conducted an evaluation of this activity, **describe**. If you have not conducted an evaluation, **describe** how you will evaluate the activities.0

The expected results of all activities are to work towards the achievement of the goals established by the Office of Early Care and Education. The five goals are:

1. **Improve and maintain the quality and quantity of early care and education programs and services.**
2. **Increase the skills, education levels, and professionalism in the field.**
3. **Increase the compensation, wages, benefits, and working conditions for early childhood professionals through public awareness, policy, and funding efforts.**
4. **Increase parent's/guardians knowledge and ability to understand the importance of early care and education to be involved in their children's learning, and to make informed child care choices.**
5. **Improve the quality of early care and education programs and services, by providing services for identified children with special needs.**

As part of an evaluation of all activities, indicators have been developed to assess of the implementation of programs. Data is currently being collected and the first report is expected to be available by October 2007.

A sample of indicators include: number of trainings provider; results of satisfaction survey for trainings; number of participant completing programs resulting in a certificate or degree; report of increase in salary; number of initial child care licenses and renewals; number of Part C eligible children placed in child care; number of centers or home-based providers achieving accreditation; number of

scholarships granted; and increases in literacy skills as demonstrated by standardized measures.

5.2 *Good Start, Grow Smart* Planning and Development

This section of the Plan relates to the President's *Good Start, Grow Smart* initiative which is envisioned as a Federal-State partnership that creates linkages between CCDF, including funds set-aside for quality, and State public and private efforts to promote early learning. In this section, each Lead Agency is asked to assess its State's progress toward developing voluntary guidelines on language, literacy, pre-reading, and early math concepts and a plan for the education and training of child care providers. The third component of the President's *Good Start, Grow Smart* initiative, planning for coordination across at least four early childhood programs and funding streams, was addressed in Section 2.1.2.

5.2.1 **Status of Voluntary Early Learning Guidelines**. **Indicate** which of the following best describes the current status of the State's efforts to develop, implement, or revise research-based early learning guidelines (content standards) for three to five year-olds. **NOTE: Check only one box to best describe the status of your State's three-to-five-year-old guidelines.**

☐ **Planning**. The State is planning for the development of early learning guidelines. Expected date of plan completion: _____

☐ **Developing**. The State is in the process of developing early learning guidelines. Expected date of completion: _____

☐ **Developed**. The State has approved the early learning guidelines, but has not yet developed or initiated an implementation plan. The early learning guidelines are included as **Attachment 5.2.1**.

☒ **Implementing**. In addition to having developed early learning guidelines, the State has embarked on implementation efforts which may include dissemination, training or embedding guidelines in the professional development system. The guidelines are included as **Attachment 5.2.1**.

☐ **Revising**. The State has previously developed early learning guidelines and is now revising those guidelines. The guidelines are included as **Attachment 5.2.1**.

☐ **Other (describe)**:

Describe the progress made by the State in developing, implementing, or revising early learning guidelines since the date of submission of the 2006-2007 State Plan.

Guidebooks for teachers and families on the Math section of the Pre-K Standards have been printed and distributed. Training for trainers has been offered throughout the state on the Math section. Guidebooks for the Social-Emotional and Music sections are scheduled to be completed by July, 2007 with the remaining sections to be completed thereafter.

If developed, are the guidelines aligned with K-12 content standards or other standards (e.g., Head Start Child Outcomes, State Performance Standards)?

☒ Yes. If yes, **name standards**.

Aligned with K-12 content standards and the Head Start Child Outcomes

☐ No.

If developed, are the guidelines aligned with early childhood curricula?

☐ Yes. If yes, **describe**.

☒ No.

Have guidelines been developed for children in the following age groups (check if guidelines have been developed):

☐ Birth to three. Guidelines are included as Attachment 5.2.1

☐ Birth to five. Guidelines are included as Attachment 5.2.1

☐ Five years or older. Guidelines are included as Attachment 5.2.1

Efforts to develop early learning guidelines for children that may differ from those addressed in *Good Start, Grow Smart* (i.e., children birth to three or older than five) may be described here.

A steering committee has been formed to begin writing standards for children birth to three. Writing groups have begun working and will align the standards with the pre-k standards. Work is expected to be completed by the end of 2007.

If any of your guidelines are available on the web, provide the appropriate Web site address (guidelines must still be attached to Plan):

NV Pre-K Standards and guidebooks for teacher and families on language & literacy and math can be found on the Office of Early Care and Education website: http://welfare.state.nv.us/child_care/earlycare.htm

5.2.2 **Domains of Voluntary Early Learning Guidelines.** Do the guidelines for children three-to-five-years-old address language, literacy, pre-reading, and early math concepts?

☒ Yes.

☐ No.

Do the guidelines for children three-to-five-years-old address domains not specifically included in *Good Start, Grow Smart*, such as social/emotional, cognitive, physical, health, creative arts, or other domains?

☒ Yes. If yes, **describe**.

The areas included in the NV Pre-K Standards are:

- **Language/Literacy**
- **Physical Development**
- **Creative Arts**
- **Science**
- **Math**
- **Social Emotional/Social Studies**

☐ No.

5.2.3 **Implementation of Voluntary Early Learning Guidelines. Indicate** the strategies the State used or expects to use in **implementing** its early learning guidelines.

Check all that apply:

☒ Disseminating materials to practitioners and families

☒ Developing training curricula

☒Partnering with other training entities to deliver training

☐ Aligning early learning guidelines with licensing, core competencies, and/or quality rating systems

☐ Other. Describe:

Indicate the stakeholders that are (or expect to be) actively supporting the implementation of early learning guidelines.	**Indicate** the programs that mandate or require the use of early learning guidelines.
☒ Publicly funded (or subsidized) child care	☐ Publicly funded (or subsidized) child care
☒ Head Start	☐ Head Start
☒ Education/Public pre-k	☒ Education/Public pre-k
☒ Early Intervention	☐ Early Intervention
☒ Child Care Resource and Referral	☐ Child Care Resource and Referral
☒ Higher Education	☐ Higher Education
☐ Parent Associations	☐ Parent Associations
☐ Other. Describe:	☐ Other. Describe:

How are (or will) cultural, linguistic and individual variations (be) acknowledged in implementation?

As part of the training for trainers, an introduction is given that includes information on inclusion and diversity in early childhood education as well as involving and working with diverse families.

The Guiding Principles in the development of the standards:

1. **Children are active learners**
2. **Development and learning are interrelated**
3. **Growth and learning are sequential**
4. **Each child is an individual learner**
5. **Development and learning are embedded in culture**
6. **Family involvement is necessary**
7. **Children's learning can be clarified, enriched, and extended.**

(Guiding principles taken from, with permission: *Pre-K Standards: Guidelines for Teaching and Learning* CTB/McGraw Hill LLC.)

How are (or will) the diversity of child care settings (be) acknowledged in implementation?

The training for trainers institute is offered to trainers that come from a variety of settings including the for profit and non profit child care centers, pre-k programs located in school districts, Head Start programs, and home providers. Additional in-service training will be provided to high school teachers who teach Child Development I and II in Las Vegas. They will then be able to teach students who will go on to work in a variety of early childhood settings.

Materials developed to support implementation of the guidelines are included as **Attachment 5.2.3**. If these are available on the web, provide the appropriate Web site address:

NV Pre-K Standards and guidebooks for teacher and families on language & literacy and math can be found on the Office of Early Care and Education website.

http://welfare.state.nv.us/child_care/earlycare.htm

5.2.4 **Assessment of Voluntary Early Learning Guidelines.** As applicable, **describe** the State's plan for:

(a) Validating the content of the early learning guidelines

(b) Assessing the effectiveness and/or implementation of the guidelines

(c) Assessing the progress of children using measures aligned with the guidelines

(d) Aligning the guidelines with accountability initiatives

Through the Office of Early Care and Education Outcomes Project, indicators have been developed to assess of the implementation of the pre-k standards and accompanying guidebooks. That data is currently being collected. Assessment of children that is aligned with the pre-k standards is in the initial stage of development, but will be addressed after the completion of the birth to three standards.

Written reports of these efforts are included as **Attachment 5.2.4**. If these are available on the web, provide the appropriate Web site address (reports must still be attached to Plan):

No written reports available at this time. The first report on the Office of Early Care and Education Outcomes Project will be completed by October 2007. This project is in the early stage of measuring implementation progress of all programs funded by CCDF set aside for quality activities.

5.2.5 **State Plans for Professional Development**. **Indicate** which of the following best describes the current status of the State's efforts to develop a professional development plan for early childhood providers that includes all the primary sectors: child care, Head Start, and public education. **NOTE: Check ONLY ONE box to best describe the status of your State's professional development plan.**

☐ **Planning**. **Indicate** whether steps are under way to develop a plan. If so, describe the entities involved in the planning process, time frames for completion and/or implementation, the steps anticipated, and how the plan is expected to support early language, literacy, pre-reading and early math concepts.

☐ **Developing**. A plan is being drafted. The draft or planning documents are included as **Attachment 5.2.5**.

☐ **Developed**. A plan has been written but has not yet been implemented. The plan is included as **Attachment 5.2.5**.

☒ **Implementing**. A plan has been written and is now in the process of being implemented, or has been implemented. The plan is included as **Attachment 5.2.5**.

☐ **Revising.** The State previously developed a professional development plan and is now revising that plan, or has revised it since submitting the 06-07 State Plan. The revisions or the revised plan are included as **Attachment 5.2.5**.

☐ **Other (describe)**:

Describe the progress made by the State in planning, developing, implementing, or revising the professional development plan since the date of submission of the 2006-2007 State Plan.

Nevada's Professional Development Plan has been revised and is currently being implemented.

If your State has developed a plan for professional development, does the plan include (**Check EITHER yes or no for each item**):

	Yes	No
Specific goals or desired outcomes	☐	☒
A link to Early Learning Guidelines	☒	☐
Continuum of training and education to form a career path	☒	☐
Articulation from one type of training to the next	☐	☒
Quality assurance through approval of trainers	☒	☐
Quality assurance through approval of training content	☒	☐
A system to track practitioners' training	☒	☐
Assessment or evaluation of training effectiveness	☒	☐
State Credentials – State for which roles (e.g. infant and toddler credential, directors' credential, etc.)	☐	☒
Specialized strategies to reach family, friend and neighbor caregivers	☐	☒

For each **Yes** response, **reference** the page(s) in the plan and briefly **describe**.

Nevada's Professional Development Plan includes:

- **A link to the Pre-k Standards (pg 6) to professional development through the development of core competencies (pg 5). Nevada's core competencies are now completed and linked to the revised Core Knowledge areas.**
- **A continuum of training and education to form a career path (pg 6) through the use of the career lattice and The Nevada Registry.**
- **Quality assurance through the approval of trainers is a future activity being currently being developed by The Nevada Registry. Criteria for trainers and implementation of this process are expected to be piloted by 2009 (pg 8).**
- **Guidelines for quality assurance through the approval of training for content have been established and are in use by The Nevada Registry (pg 8).**
- **A voluntary system to track practitioners' training is in place through The Nevada Registry (pg 6).**
- **Assessment or a standardized evaluation of training will be developed in conjunction with criteria for trainers (see above) (pg 8).**

For each **No** response, **indicate** any plans the Lead Agency has to incorporate these components.

- **Nevada's Professional Development Plan includes current activities and future plans, but does not have goals for participants. While a few outcomes have been developed to measure the knowledge gain or progress of practitioners, most outcomes developed measure the implementation progress of programs. As the outcomes project continues to collect data, additional outcomes will be developed to measure the effectiveness of the plan and programs funded by CCDF set-aside for quality activities.**
- **The plan does address articulation between community colleges (pg 8), but does not address articulation between training (informal to formal education.)**
- **While there are training and grant opportunities offered for**

  family, friend, and neighbor caregivers, the plan does not specifically address this group. The plan is based on a five-year period and if needed, they will be included when the plan is revised by 2011.

Are the professional development opportunities described in the plan available:

Note: Check either yes or no for each item):

	Yes	No
Statewide	☒	☐
To Center-based Child Care Providers	☒	☐
To Group Home Providers	☒	☐
To Family Home Providers	☒	☐
To In-Home Providers	☐	☒
Other (describe):	☐	☐

Describe how the plan addresses early language, literacy, pre-reading, and early math concepts development.

A link to the Pre-k Standards to professional development through the development of core competencies (pg 5). Nevada's core competencies are now completed and linked to the revised Core Knowledge areas.

Are program or provider-level incentives offered to encourage provider training and education?

☒ Yes. If yes, **describe**, including any connections between the incentives and training relating to early language, literacy, pre-reading and early math concepts.

Incentives are offered as part of the Child Care Apprenticeship Program and the T.E.A.C.H. Early Childhood Nevada Program for providers interested in increasing their formal education.

Stipends are also provided to trainers that attend the Pre-k Standards training institute and then provide three community trainings.

☐ No. If no, **describe** any plans to offer incentives to encourage provider training and education, including any connections between the incentives and training relating to early language, literacy, pre-reading and early math concepts?

As applicable, does the State assess the effectiveness of its professional development plan, including the achievement of any specified goals or desired outcomes?

☐ Yes. If yes, **describe** how the professional development plan's effectiveness/goal is assessed.

☒ No. If no, **describe** any plans to include assessments of the professional development plan's effectiveness/goal achievement.

Nevada's professional development plan was revised July 2006. It is too early to assess the effectiveness of the current plan. Assessment will be included in the revision of the plan in 2011.

Does the State assess the effectiveness of specific professional development initiatives or components?

☒ Yes. If yes, **describe** how specific professional development initiatives or components' effectiveness is assessed.

Through the Office of Early Care and Education outcomes have been developed to measure the implementation of programs and in the future will measure the effectiveness of the specific initiatives.

☐ No. If no, **describe** any plans to include assessments of specific professional development initiatives or components' effectiveness.

As applicable, does (or will) the State use assessment to help shape or revise its professional development plan?

☒ Yes. If yes, **describe** how assessment informs the professional development plan.

Nevada's Professional Development Plan was revised July 2006. It is too early to assess the effectiveness of the current plan. Assessment from the Office of Early Care and Education Outcomes Project, the ECCS Outcomes, and others will be included in the revision of the plan in 2011.

☐ No. If no, **describe** any plans to include assessment to inform the professional development plan.

PART 6

HEALTH AND SAFETY REQUIREMENTS FOR PROVIDERS

(Only the 50 States and the District of Columbia complete Part 6.)

The National Resource Center for Health and Safety in Child Care (NRCHSCC) of DHHS's Maternal and Child Health Bureau supports a comprehensive, current, on-line listing of the licensing and regulatory requirements for child care in the 50 States and the District of Columbia. In lieu of requiring a State Lead Agency to provide information that is already publicly available, ACF accepts this compilation as accurately reflecting the States' licensing requirements. The listing, which is maintained by the University of Colorado Health Sciences Center School of Nursing, is available on the World Wide Web at: http://nrc.uchsc.edu/.

6.1 Health and Safety Requirements for Center-Based Providers (658E(c)(2)(F), §§98.41, §98.16(j))

6.1.1 Are all center-based providers paid with CCDF funds subject to licensing under State law that is indicated in the NRCHSCC's compilation?

☐ Yes. Answer 6.1.2, skip 6.1.3, and go to 6.2.

☒ No. If no, **describe** which center-based providers are exempt from licensing under State law and answer 6.1.2 and 6.1.3.

The only center-based care not licensed in Nevada is the before and after-school care provided by the local city and county governments and the Boy's and Girl's Clubs.

6.1.2 Have center licensing requirements as they relate to staff-child ratios, group size, or staff training been modified since approval of the last State Plan? (§98.41(a)(2)&(3))

☐ Yes. If yes, **describe** the changes.

☒ No.

6.1.3 For center-based care that is NOT licensed, and therefore not reflected in NRCHSCC's compilation, the following health and safety requirements apply to child care services provided under the CCDF for:

- The prevention and control of infectious disease (including age-appropriate immunizations)

The only center-based care not licensed in Nevada is the before and after-school care provided by the local city and county governments and the Boy's and Girl's Clubs. The before and after-school services provided by the local city and county governments are provided in school buildings and all participants are school children. Therefore, they are all immunized and their records are kept in their local school district. The Boy's and Girl's Clubs check immunizations once a year when they check income eligibility.

- Building and physical premises safety

The local city and county before and after-school programs are operated in school buildings and therefore are subject to building and physical premises safety for school buildings, which is in state law. The Boy's and Girl's Clubs facilities must meet all code requirements established by the jurisdiction they are in.

- Health and safety training

All before and after-school staff receive First Aid and CPR training as well as information on infectious diseases. In addition, the before and after-school programs work with the school nurses to enhance health and safety training.

6.2 Health and Safety Requirements for Group Home Providers (658E(c)(2)(F), §§98.41, 98.16(j))

6.2.1 Are all group home providers paid with CCDF funds subject to licensing under State law that is indicated in the NRCHSCC's compilation? If:

☒ Yes. Answer 6.2.2, skip 6.2.3, and go to 6.3.

☐ No. If no, **describe** which group home providers are exempt from licensing under State law and answer 6.2.2 and 6.2.3.

6.2.2 Have group home licensing requirements that relate to staff-child ratios, group size, or staff training been modified since the approval of the last State Plan? (§98.41(a)(2) & (3))

☐ Yes. If yes, d**escribe** the changes.

☒ No.

6.2.3 For group home care that is NOT licensed, and therefore not reflected in NRCHSCC's compilation, the following health and safety requirements apply to child care services provided under the CCDF for: **N/A**

- The prevention and control of infectious disease (including age-appropriate immunizations)
- Building and physical premises safety
- Health and safety training

6.3 Health and Safety Requirements for Family Providers (658E(c)(2)(F), §§98.41, 98.16(j))

6.3.1 Are all family child care providers paid with CCDF funds subject to licensing under State law that is indicated in the NRCHSCC's compilation? If:

☐ Yes. Answer 6.3.2, skip 6.3.3, and go to 6.4.

☒ No. If no, **describe** which family child care providers are exempt from licensing under State law and answer 6.3.2 and 6.3.3.

Kith and Kin providers who register with the contractors.

6.3.2 Have family child care provider requirements that relate to staff-child ratios, group size, or staff training been modified since the approval of the last State Plan? (§98.41(a)(2) & (3))

☐ Yes. If yes, **describe** the changes.

☒ No.

6.3.3 For family care that is NOT licensed, and therefore not reflected in NRCHSCC's compilation, the following health and safety requirements apply to child care services provided under the CCDF for:

- The prevention and control of infectious disease (including age-appropriate immunizations)

The prevention and control of infectious disease is satisfied through regular workshops available to all child care providers or self-guided training modules. All unlicensed providers must meet this requirement. A copy of the child's immunization record is kept on file with the provider for children under the age of five (5). School

age children's immunization records are on file with their local school.

- Building and physical premises safety

Information is made available through the contractors and/or state staff to the providers concerning building and physical premises safety. In addition, the contractor and/or state quality assurance staff completes a home visit within 45 days of the provider's registration to check for health and safety concerns. Follow up visits are completed every six (6) months.

- Health and safety training

Each contractor and/or state staff provides the equivalent of 3 hours of health and safety training for non-licensed family care providers through the use of materials. In addition, the video training series is currently available, which includes health and safety.

Additionally, through Nevada's Community Integrated Service System (C.I.S.S.) there are trained consultants who work with child care providers to improve health practices in child care. Nevada also has mental health consultants who work with child care providers who are having problems with children with behavioral or emotional difficulties.

6.4 Health and Safety Requirements for In-Home Providers (658E(c)(2)(F), §§98.41, 98.16(j))

6.4.1 Are all in-home child care providers paid with CCDF funds subject to licensing under the State law reflected in the NRCHSCC's compilation referenced above?

☐ Yes. Answer 6.4.2, skip 6.4.3, and go to 6.5.

☒ No. If no, **describe** which in-home child care providers are exempt from licensing under State law and answer 6.4.2 and 6.4.3.

In home providers in rural Nevada who care for four (4) children or less are not required to be licensed.

6.4.2 Have in-home health and safety requirements that relate to staff-child ratios, group size, or training been modified since the approval of the last State Plan? (§98.41(a)(2) & (3))

☐ Yes. If yes, **describe** the changes.

☒ No.

6.4.3 For in-home care that is NOT licensed, and therefore not reflected in NRCHSCC's compilation, the following health and safety requirements apply to child care services provided under the CCDF for:

- The prevention and control of infectious disease (including age-appropriate immunizations)

The prevention and control of infectious disease is satisfied through the regular workshops available to all child care providers or self-guided training modules. All unlicensed providers must meet this requirement. A copy of the child's immunization record is kept on file with the provider for children under the age of five (5). School age children's immunization records are on fie with their local school.

- Building and physical premises safety

Information is made available to parents through contractor and/or state staff on building and physical premises safety.

- Health and safety training

Information is made available through contractor and/or state staff to parents concerning health and safety. In addition, two modules of the video training series are currently available in libraries across Nevada, which includes health and safety.

6.5 Exemptions to Health and Safety Requirements

At Lead Agency option, the following relatives: grandparents, great grandparents, aunts, uncles, or siblings (who live in a separate residence from the child in care) may be exempted from health and safety requirements. (658P(4)(B), §98.41(a)(1)(ii)(A)) Indicate the Lead Agency's policy regarding these relative providers:

☐ **All** relative providers are subject to the same requirements as described in sections 6.1 - 6.4 above, as appropriate; there are **no exemptions** for relatives or different requirements for them.

☐ **All** relative providers are **exempt** from all health and safety requirements.

☒ **Some or all** relative providers are subject to different health and safety requirements from those described in sections 6.1 - 6.4. The following describes those requirements and identifies the relatives they apply to:

In home care and care provided by a "qualified relative" in their home is exempt from the health and safety requirements. However, the parent can request a home visit for evaluation and recommendations for improvements are made if necessary.

6.6 Enforcement of Health and Safety Requirements

Each Lead Agency is required to certify that procedures are in effect to ensure that child care providers of services for which assistance is provided comply with all applicable health and safety requirements. (658E(c)(2)(E), §§98.40(a)(2), 98.41(d)) The following is a description of how health and safety requirements are effectively enforced:

- Are child care providers subject to routine unannounced visits (i.e., not specifically for the purpose of complaint investigation or issuance/renewal of a license)?

  ☒ Yes. If yes, **indicate** which providers are subject to routine unannounced visits and the frequency of those visits:

  All licensed child care providers are visited at least twice each year by a respective licensing entity. Unlicensed providers who are registered with the State's contractors and receiving subsidies are also visited at least twice a year but by contract and/or state staff.

☐ No.

- Are child care providers subject to background checks?

☒ Yes. If yes, **indicate** which types of providers are subject to background checks and when such checks are conducted:

All licensed providers are subject to background checks. If a provider is not required to be licensed but is registered with the State's contractors, the parent decides if they want the unlicensed provider they have chosen, to have their background checked.

☐ No.

- Does the State require that child care providers report serious injuries that occur while a child is in care? (Serious injuries are defined as injuries requiring medical treatment by a doctor, nurse, dentist, or other medical professional.)

☒ Yes. If yes, **describe** the State's reporting requirements and how such injuries are tracked (if applicable):

NAC 432A.378 Reports of accident, injury, communicable disease or death.

1. **Upon the occurrence of any accident or injury which requires emergency professional medical care of a child, the director, operator or owner of each facility shall report the occurrence to the bureau or local licensing agency as soon as possible and shall keep on file at the facility a report of the occurrence.**

2. **If the director, operator or owner of a facility finds that any reportable communicable disease may be present in the facility, he shall report that condition to the bureau or local licensing agency as soon as possible. The bureau or local licensing agency shall provide the list of reportable communicable diseases to all licensees and applicants.**

3. The director, operator or owner of each facility shall report as soon as possible to the bureau or local licensing agency the death of any child who attends or lives in the facility.

NAC 432A.410 Reports of child abuse or neglect. If any person suspects that child abuse or neglect is occurring in a facility, the person may immediately report his suspicions to the bureau. Every licensee or employee of a facility who has reason to believe child abuse or neglect is occurring in the facility, in the child's home or elsewhere shall report his beliefs to the appropriate authority as required in NRS 432B.220.

☐ No.

- Other methods used to ensure that health and safety requirements are effectively enforced: **N/A**

6.7 Exemptions from Immunization Requirements

The State assures that children receiving services under the CCDF are age-appropriately immunized, and that the health and safety provisions regarding immunizations incorporate (by reference or otherwise) the latest recommendations for childhood immunizations of the State public health agency. (§98.41(a)(1))

The State exempts the following children from immunization (check all that apply):

☐ Children who are cared for by relatives (defined as grandparents, great grandparents, siblings (if living in a separate residence), aunts and uncles).

☐ Children who receive care in their own homes.

☒ Children whose parents object to immunization on religious grounds.

☒ Children whose medical condition contraindicates immunization.

NRS. 432A.230 Certificate of immunization prerequisite to admission to child care facility; conditional admission; report to health division.

1. Except as otherwise provided in subsection 3 and unless excused because of religious belief or medical condition, a child may not

be admitted to any child care facility within this state, including a facility licensed by a county or city, unless his parents or guardian submit to the operator of the facility a certificate stating that the child has been immunized and has received proper boosters for that immunization or is complying with the schedules established by regulation pursuant to NRS 439.550.

PART 7

HEALTH AND SAFETY REQUIREMENTS IN THE TERRITORIES

(Only the Territories complete Part 7)

7.1 Health and Safety Requirements for Center-Based Providers in the Territories

(658E(c)(2)(F), §98.41(a), §98.16(j))

For all center-based care, the following health and safety requirements apply to child care services provided under the CCDF for:

- The prevention and control of infectious disease (including age-appropriate immunizations)
- Building and physical premises safety
- Health and safety training

7.2 Health and Safety Requirements for Group Home Providers in the Territories

(658E(c)(2)(F), §98.41(a), §98.16(j))

For all group home care, the following health and safety requirements apply to child care services provided under the CCDF for:

- The prevention and control of infectious disease (including age-appropriate immunizations)
- Building and physical premises safety
- Health and safety training

7.3 Health and Safety Requirements for Family Providers in the Territories

(658E(c)(2)(F), §98.41(a), §98.16(j))

For all family child care, the following health and safety requirements apply to child care services provided under the CCDF for:

- The prevention and control of infectious disease (including age-appropriate immunizations)
- Building and physical premises safety
- Health and safety training

7.4 Health and Safety Requirements for In-Home Providers in the Territories

(658E(c)(2)(F), §98.41(a), §98.16(j))

For all in-home care, the following health and safety requirements apply to child care services provided under the CCDF for:

- The prevention and control of infectious disease (including age-appropriate immunizations)
- Building and physical premises safety
- Health and safety training

7.5 Exemptions to Territorial Health and Safety Requirements

At Lead Agency option, the following relatives may be exempted from health and safety requirements: grandparents, great grandparents, aunts, uncles, or siblings (who live in a separate residence from the child in care). (658P(4)(B), §98.41(a)(1)(ii)(A)). Indicate the Lead Agency's policy regarding these relative providers:

☐ **All** relative providers are subject to the same requirements as described in sections 7.1 - 7.4 above, as appropriate; there are **no exemptions** for relatives or different requirements for them.

☐ **All** relative providers are **exempt** from all health and safety requirements.

☐ **Some or all** relative providers are subject to **different** health and safety requirements from those described in sections 7.1 - 7.4 and the following describes those different requirements and the relatives they apply to:

7.6 Enforcement of Territorial Health and Safety Requirements

Each Lead Agency is required to certify that procedures are in effect to ensure that child care providers of services for which assistance is provided comply with all applicable health and safety requirements. (658E(c)(2)(E), §§98.40(a)(2), 98.41(d)) The following is a description of how Territorial health and safety requirements are effectively enforced:

Are child care providers subject to routine unannounced visits (i.e., not specifically for the purpose of complaint investigation or issuance/renewal of a license)?

☐ Yes. If yes, **indicate** which providers are subject to routine unannounced visits and the frequency of those visits:

☐ No.

Are child care providers subject to background checks?

☐ Yes. If yes, **indicate** which types of providers are subject to background checks and when such checks are conducted:

☐ No.

Does the Territory require that child care providers report serious injuries that occur while a child is in care? (Serious injuries are defined as injuries requiring medical treatment by a doctor, nurse, dentist, or other medical professional.)

☐ Yes. If yes, **describe** the Territory's reporting requirements and how such injuries are tracked (if applicable):

☐ No.

Other methods used to ensure that health and safety requirements are effectively enforced:

7.7 Exemptions from Territorial Immunization Requirements

The Territory assures that children receiving services under the CCDF are age-appropriately immunized, and that the health and safety provisions regarding immunizations incorporate (by reference or otherwise) the latest recommendations for childhood immunizations of the Territorial public health agency. (§98.41(a)(1))

The Territory exempts the following children from immunization (check all that apply):

☐ Children who are cared for by relatives (defined as grandparents, great grandparents, siblings (if living in a separate residence), aunts and uncles).

☐ Children who receive care in their own homes.

☐ Children whose parents object to immunization on religious grounds.

☐ Children whose medical condition contraindicates immunization.

APPENDIX 1

PROGRAM ASSURANCES AND CERTIFICATIONS

The Lead Agency, named in Part 1 of this Plan, assures that:

(1) upon approval, it will have in effect a program that complies with the provisions of the Plan printed herein, and is administered in accordance with the Child Care and Development Block Grant Act of 1990 as amended, Section 418 of the Social Security Act, and all other applicable Federal laws and regulations. (658D(b), 658E(a))

(2) the parent(s) of each eligible child within the State who receives or is offered child care services for which financial assistance is provided is given the option either to enroll such child with a child care provider that has a grant or contract for the provision of the service; or to receive a child care certificate. (658E(c)(2)(A)(i))

(3) in cases in which the parent(s) elects to enroll the child with a provider that has a grant or contract with the Lead Agency, the child will be enrolled with the eligible provider selected by the parent to the maximum extent practicable. (658E(c)(2)(A)(ii))

(4) the child care certificate offered to parents shall be of a value commensurate with the subsidy value of child care services provided under a grant or contract. (658E(c)(2)(A)(iii))

(5) with respect to State and local regulatory requirements, health and safety requirements, payment rates, and registration requirements, State or local rules, procedures or other requirements promulgated for the purpose of the Child Care and Development Fund will not significantly restrict parental choice among categories of care or types of providers. (658E(c)(2)(A), §98.15(p), §98.30(g), §98.40(b)(2), §98.41(b), §98.43(c), §98.45(d))

(6) that children receiving services under the CCDF are age-appropriately immunized, and that the health and safety provisions regarding immunizations incorporate (by reference or otherwise) the latest recommendation for childhood immunizations of the State public health agency. (§98.41(a)(1))

(7) that CCDF Discretionary funds are used to supplement, not supplant, State general revenue funds for child care assistance for low-income families. (P.L. 109-149)

The Lead Agency also certifies that:

(1) it has procedures in place to ensure that providers of child care services for which assistance is provided under the Child Care and Development Fund afford parents unlimited access to their children and to the providers caring for their children during the normal hours of operations and whenever such children are in the care of such providers. (658E(c)(2)(B))

(2) it maintains a record of substantiated parental complaints and makes information regarding such complaints available to the public on request. (658E(c)(2)(C))

(3) it will collect and disseminate to parents of eligible children and the general public, consumer education information that will promote informed child care choices. (658E(c)(2)(D))

(4) it has in effect licensing requirements applicable to child care services provided in the State. (658E(c)(2)(E))

(5) there are in effect within the State (or other area served by the Lead Agency), under State or local law, requirements designed to protect the health and safety of children; these requirements are applicable to child care providers that provide services for which assistance is made available under the Child Care and Development Fund. (658E(c)(2)(E))

(6) procedures are in effect to ensure that child care providers of services for which assistance is provided under the Child Care and Development Fund comply with all applicable State or local health and safety requirements. (658E(c)(2)(G))

(7) payment rates under the Child Care and Development Fund for the provision of child care services are sufficient to ensure equal access for eligible children to comparable child care services in the State or sub-State area that are provided to children whose parents are not eligible to receive assistance under this program or under any other Federal or State child care assistance programs. (658E(c)(4)(A))

APPENDIX 2

ELIGIBILITY AND PRIORITY TERMINOLOGY

For purposes of determining eligibility and priority for CCDF-funded child care services, lead agencies must **define** the following *italicized* terms. (658P, 658E(c)(3)(B))

- *attending* (a job training or educational program; include minimum hours if applicable) -

  Requires enrollment at the time of initial determination of eligibility and adequate progress toward program completion at subsequent eligibility reviews.

- *in loco parentis* –

  Adult(s) standing in as parent(s) for children who are in need of supervision or protective services such as a blood relative with custody or any person with court ordered custody, and for families who are in transition.

- *job training and educational program* –

  A structured course of study, which is recognized by an applicable licensing, certification or accreditation body and is designed to lead to employment within a reasonable period to time.

- *physical or mental incapacity* (if the Lead Agency provides such services to children age 13 and older) –

  A physical or mental condition, which severely limits the individual's ability to care for him/herself, or an emotional condition that places the individual or others at risk, as verified by a physician or other licensed professional authorized to make such assessments.

- *protective services* –

Services for children who have been abused or neglected or who are at risk of abuse or neglect as determined by a professional in the field or by a court. There may be circumstances where it is in the best interests of the child as well as the family the child was placed with, to provide short term respite services.

- *residing with* –

  Living with a custodial parent or guardian in the domicile of the custodial parent or guardian who provides primary care and support to the child.

- *special needs child* –

  A child, under the age of 19, who has a physical, mental or emotional impairment as verified by a physician or other licensed professional authorized to make such assessments.

-

- *very low income* –

  A family whose income is at or below 130percent of the Federal Poverty Level by family size.

- *working* (include minimum hours if applicable) –

  Providing services or a product for monetary compensation.

- Additional terminology related to conditions of eligibility or priority established by the Lead Agency:

  Purpose of care - an approved activity which does not allow for the parent/caretaker to care for the child(ren). Purpose of care can be employment, training, educational classes, seeking employment, temporary disability or Division of Welfare and Supportive Services approved activities related to the preparation for employment.

  Qualified Relative – a grandparent, great-grandparent, uncle, aunt, or adult sibling living in a separate residence.

Appendix B: Nevada's Professional Recognition Opportunities for Individual Teachers' Success (PROFITS)

July 1, 2006 – June 30, 2011

Submitted by the Office of Early Care and Education

Division of Welfare and Supportive Services

- Jerry Allen, Child Care Administrator

Office of Early Care and Education

- Cindy Johnson
- Christine Matiash
- Patti Oya

The Office of Early Care and Education would like to thank the following for their participation and assistance in development of this plan:

- Marci Behmaram, UNR Campus Child Care Connections
- Kimberlee Belcher, T.E.A.C.H. Early Childhood NV
- Jaime Burnett, Children's Cabinet
- Teresa Byington, UNR Cooperative Extension
- Leslie Chaney, NV Child Care Apprenticeship Program
- Margot Chappel, Independent Contractor
- Kyle Devine, NV Health Division, ECCS Grant
- Donna Durham, NV Bureau of Services for Child Care
- Eva Essa, UNR Human Development and Family Studies
- Joanne Everts, Washoe County School District
- Peggy Fouts, NV Association for the Education of Young Children
- Shari Fyfe, NV Early Intervention Services
- Paula Hawkins, NV Bureau of Services for Child Care
- Molly Hayes, Nellis Air Force Base Child Development Center II
- Alice LeDesma, Washoe County Department of Social Services
- Janie Lowe, NV Department of Education
- Catherine Lyons, UNLV Department of Special Education
- Sally Martin, UNR Cooperative Extension
- Shelly Nye, NV The Nevada Registry
- Pat Perryman, NV Bureau of Services for Child Care
- Lisa Roberts, NV Bureau of Services for Child Care
- Irene Rogerson, NV Child Care Apprenticeship Program

- Crystal Swank, Truckee Meadows Community College
- Daniel Voges, Clark County Child Care Assistance Division
- Sherry Waugh, UNR Child and Family Research Center

A special thank you to Margot Chappel for providing much of the documentation of the history and to all those individuals who have worked untiringly to improve the quality of early childhood services for families and professionals by developing the programs and initiatives included in this framework.

The Nevada Office of Early Care and Education was established in July 2001 under the Division of Welfare and Supportive Services to oversee the Child Care and Development Funds (CCDF), Quality Earmarks. The vision of this office is to promote and provide support, education, and resources to Nevada's child care community thereby increasing the development of high-quality child care environments for providers, families, and children.

The goals of the Office of Early Care and Education are:

1. Improve and maintain the quality and quantity of early care and education programs and services. *Implicit in the definition of "quality" is safe, healthy, and developmentally appropriate services. This includes both licensed and non-licensed services.*

2. Increase the skills, education levels, and professionalism of field.

3. Increase the compensation, wages, benefits, and working conditions for early childhood professionals through public awareness, policy, and funding efforts. *This includes public awareness, policy, and funding efforts to highlight the importance of quality early care and education in child development.*

4. Increase parents'/guardians' knowledge and ability to understand the importance of early care and education, to be involved in their child's learning, and to make informed child care choices.

5. Improve the quality of early care and education programs and services, by providing quality intervention services for identified children with special needs.

The documentation of a professional development system will guide the work of the Office of Early Care and Education. Nevada's professional development system follows the framework set by the National Child Care Information Center (NCCIC). The framework consists of five elements: 1) Funding, 2) Core Professional Core Knowledge Area, 3) Qualifications and Credentials, 4) Quality Assurances, and 5) Access and Outreach. Each section will address the history, current status, and activities of quality initiatives relevant to the element. It will also include information from other agencies and collaborative efforts when known.

Nevada's Professional Recognition Opportunities for

Individual Teachers' Success (PROFITS)

Mission: Nevada's PROFITS works to ensure all young children receive an equal opportunity to become well-educated, emotionally stable, contributing members of society, thus leading to the success of Nevada. This is achieved by supporting the educational and professional growth of early childhood educators.

ELEMENT 1 - FUNDING

Scholarships for Professional Development, Courses, Degrees

History:

Nevada has provided college scholarships for Early Care and Education professionals since 1998. Additionally, the Nevada Child Care Apprenticeship Program provides financial assistance, education and training for novice early care and education teachers. Entry-level teachers are encouraged to climb the Career Ladder. The program also promotes completion of the apprenticeship certification as well as continuing education beyond the apprenticeship and journeyman levels to completion of associate or bachelor degrees in Early Childhood Education.

In 2005 the Nevada Association for the Education of Young Children (NevAEYC) was awarded a grant to administer the T.E.A.C.H. Early Childhood® NEVADA program. T.E.A.C.H. addresses early childhood education needs, compensation, turn-over, and the professionalism of Early Care and Education providers in Nevada. The program provides scholarships for Home Care Providers, Center Providers, or Center Directors working in a licensed facility. Scholarships pay for 80percent of tuition, 80percent of books, $50 per semester for travel, and a $250-$400 bonus in conjunction with a 2percent wage increase provided by employers. Scholarship recipients commit to working with the sponsoring center for at least one additional year, following the completion of the scholarship.

Current Status:

Scholarships for Professional Development/Informal Training

- Scholarships are available for the annual Nevada Association for the Education of Young Children conference (Statewide)
- Scholarships are available for the cost associated with the CDA program. (Southern Nevada)

Scholarships for Courses

- Scholarships for 21 college credits are available under the NV Child Care Apprenticeship Program. When completed, apprentices receive a child development certificate from the US Department of Labor. (Statewide)
- Scholarships are available for early childhood certificates for teachers and directors in early childhood education through the T.E.A.C.H. program (Statewide)
- Scholarships for six college credits are available through the NV Health Division Early Intervention Partners Program. This program was developed to train child care providers in the community about including children with disabilities in their child care settings. Child care providers can receive both formal training through classes offered at TMCC and informal technical assistance that is provided on-site by early intervention consultants thereby improving quality child care for all children (Northern Nevada)

Scholarships for Degrees

- Scholarships are available for AA degrees in early childhood education through the T.E.A.C.H. program (Statewide)
- Scholarships are available for a BA degree in early childhood education through the T.E.A.C.H. program (Northern Nevada)
- Scholarships are available for a BA degree in early childhood, non-license administration option through the 2+2 Program (Southern Nevada)

Future Activities:

- To increase funding for the T.E.A.C.H. Early Childhood Nevada program so participants statewide are able to earn a BA Degree

Compensation/Retention Initiatives

History:

Both the NV Child Care Apprenticeship program and the T.E.A.C.H. program includes components of a wage increase and/or bonus for participants meeting program requirements.

Current Status:

The Office of Early Care and Education is collaborating with the Nevada Association for the Education Young Children (NevAEYC) to design a model for a compensation initiative.

Future Activities:

- To fund and implement a compensation initiative

Program Quality Awards

History:

In 2002, the State Child Care Advisory Committee adopted a tiered reimbursement child care subsidy structure. Implementation of Tier 4 began immediately. Accredited centers and family home providers who were active participants in the Nevada Child Care Subsidy Program began receiving a 15percent increase in their subsidy payment. Barriers to implementing the tiered reimbursement system as it was originally developed were found. Specifically, Tiers 2 and 3 required the rating of facilities using a nationally recognized, standardized rating scale (i.e., ECERS, ITERS, FDCRS, etc.). The cost of implementing such a system is high and thus has been tabled.

Current Status:

An Accreditation Facilitation Project is available statewide to assist family home providers and child care facilities who are interested in achieving national accreditation. The Project includes funds for fees associated with the cost of accreditation, quality improvement grants, staff training and classroom observation, and a bonus for attaining accreditation. When a center or family home provider achieves accreditation, they are placed on Tier 4 and eligible to receive an increase of 15percent over the current subsidy rate. There are currently 31 centers on Tier 4. At this time, there are no direct payments based on quality that are <u>not</u> tied to state child care subsidy dollars. Discussion of a quality rating system has begun. However, the realization that programs need to be in place to support the workforce and child care facilities before a rating system is implemented makes this a long-term goal.

Future Activities

- Form a workgroup to discuss the feasibility of implementing Tiers 2 and 3. Possible ideas include a tiered reimbursement system that does not include a rating score as part of the requirements, removing Tiers 2 and 3 all together, or integrating the tiered reimbursement system with a quality rating system
- To design and pilot a quality rating system

ELEMENT 2 – CORE PROFESSIONAL KNOWLEDGE

<u>Core Body of Knowledge Area/Core Competencies</u>

History:

The State Child Care Advisory Board adopted Core Knowledge Areas (CKA's) in 2002. The following year a committee of Early Care and Education professionals worked with staff from The Nevada Registry Office to modify the CKA's for practical use in approving and tracking training. These CKA's are in use as The Nevada Registry Office approves training statewide.

Current Status:

A workgroup of early childhood professionals are completing a revision of the Core Knowledge Areas which will more accurately cover required training topics being offered in Nevada. This workgroup is also developing core competencies for each CKA. Each CKA will have several competencies which will be met on a beginner, intermediate and advanced levels.

Future Activities:

- ***Develop a self-measurement tool that practitioners can use to assess one's own level of competency within the Core Knowledge Areas***
- ***Designate levels of mastery connected to a progression of service roles in the field need to be developed (i.e., those skills linked with being a teacher, director, administrator, family child care provider, etc.)***

- ***This input will be utilized to "tweak" the competencies and prepare for general usage***
- ***Dissemination of the final document is tentatively scheduled for early 2007***

Career Lattice

History:

The State Child Care Advisory Board adopted Nevada's Early Care and Education Professional Career Ladder in April 2002. The Career Ladder is now being utilized on a statewide basis with over 1,000 Early Care and Education professionals registered.

Current Status:

Participation with The Nevada Registry is currently voluntary. However, the Bureau of Services for Child Care is in the process of revising the State Child Care Licensing regulations. Mandatory participation, more specifically, Career Ladder placement with The Nevada Registry is one of the proposed changes that the Child Care Licensing Board will be considering. We will be able to have a more accurate picture of Nevada's ECE workforce by making this a requirement for all employees working in licensed child care programs.

Future Activities:

- Continue to increase the number of Career Ladder participants
- Increase overall funding for The Nevada Registry to adequately support increased staffing needs that will occur as a result of mandatory participation Mandatory participation will be phased-in over a four year period

Pre-K Standards

History:

Development of the Pre-K Standards began in 2003 with the establishment of writing teams for each content area. Content areas included: Language & Early Literacy, Math, Science, Social Studies (Social/Emotional), Creative Arts, Physical Development, and Health. Standards were developed by the writing teams during 4- 2 day writing sessions. A draft of the Pre-K Standards was distributed to early childhood professionals across the state for review and input. Focus groups were held to discuss the standards and obtain input in Elko, Las Vegas, Carson City and Reno. Input and suggestions were synthesized, the draft was edited, and the Steering Committee made final changes. In March 2004 the Pre-K Standards were approved by the NV Board of Education. The Pre-K Standards have been disseminated to all licensed child care facilities and pre-k programs and are also available online.

A Professional Development Committee was established and set goals for professional development and identified training models and materials for teacher and parent support to be developed.

Current Status:

Teacher and parent guidebooks have been created for the Language and Early Literacy section. Train-the-trainers sessions on Language and Early Literacy were held. A variety of training to support the Pre-K standards is available statewide.

Future Activities:

- Complete and distribute teacher and parent guidebooks for Math and Social Studies
- Provide train-the-trainers sessions for Math and Social Studies
- Begin development of standards for infants and toddlers.
- Complete and distribute teacher and parent guidebooks and provide train-the-trainers sessions for the remaining content areas of Physical Development, Health, Creative Arts, and Science
- Develop an assessment tool to align with the Pre-K Standards

ELEMENT 3 – QUALIFICATIONS AND CREDENTIALS

Pre-service Requirements and Continuing Education Requirements

Current Status:

There are minimal pre-service requirements for child care directors and no pre-service requirements for child care staff and family home providers. On-going continuing education requirements include 9 hours of initial training in health and safety within the first 90 days of employment and 6 hours of training immediately succeeding the completion of the initial training. After the first year, 15 hours of training is required annually. One area of concern that needs to be addressed regarding ongoing training is the lack of training available for more advanced providers statewide. The Nevada Association for the Education of Young Children and the University of Nevada Reno Cooperative Extension are collaborating to develop a plan for informal training which will examine the areas of need, reduce duplication of services by the various community agencies offering training, and strategize ideas for more advanced training.

Future Activities:

- To gather information and begin work on a crosswalk comparison of child care licensing regulations, public school regulations, and Head Start performance standards

Credentials

Current Status:

There is no formal credential process offered and it is not a requirement of child care licensing at this time. While the value of a directors' credential is apparent and needed, it is not part of this five-year plan. Two of the community colleges offer an Associate Degree and Certificate in early childhood with an administration emphasis.

Pathways Leading to Qualifications, Degrees, and Credentials

Current Status:

There is an articulation agreement among the community colleges regarding the early childhood courses available and the ability to transfer classes. This does not include one admission application or an agreement between community colleges and the universities. Under the Head Start State Collaboration there is a sub-committee formed to work with the issues of higher education collaboration and articulation agreements.

ELEMENT 4 – QUALITY ASSURANCES

Trainer Approval

History:

Nevada has not had an established set of criteria related to the approval of trainers. The inception of The Nevada Registry's Training Approval System in October 2004 brought about the ability to begin creating consistent standards and criteria related to the approval of trainers. Basic requirements for trainers were introduced in the first phase of implementation and as a result all ECE trainers must now apply for Career Ladder placement, complete a standardized request form, and comply with basic training approval criteria.

Current Status

Over 400 trainers and sponsors are currently registered with The Nevada Registry to provide training based on basic trainer requirements. To begin the next phase of implementation, The Nevada Registry has developed a workgroup of early care and education professionals to assist with the development of standards for the approval of trainers. A draft model is in the process of being developed. At this point, the workgroup is proposing that there be several levels based on education and training expertise of the trainer. These levels can be used as a guide to consumers as they are making choices about their own professional development.

Future Activities:

- ***Complete the development of trainer approval criteria and obtain approval from The Nevada Registry Advisory Committee***
- ***Develop a basic orientation based on adult learning principles that all trainers would be required to complete as part of the process for becoming an Approved Trainer***
- ***Develop a directory of Approved Trainers. This directory will allow ECE professionals to locate trainers who have expertise in specific areas and who have met The Nevada Registry's trainer approval criteria.***
- ***Develop a standardized evaluation tool to be used at all Nevada Registry approved trainings to determine the quality of the trainer and content of the training. This tool would be a step toward implementing a quality assurance process within The Nevada Registry's Training Approval System.***
- ***Increase funding for The Nevada Registry to support the development of the components related to the implementation of trainer approval criteria***

Training Approval

History:

In the past, training approval was completed by five different licensing entities; each with their own unique requirements and approaches to approval. This resulted in a lack of consistency across the state. In October 2004 the Bureau of Services for Child Care designated The Nevada Registry solely responsible for the approval of informal, not-for-college training on a statewide basis. This has resulted in a more standardized and consistent Training Approval System.

Current Status:

Over 5100 trainings have been approved by The Nevada Registry to date. The program is currently developing an online process for training approval that will allow trainers and sponsors to submit training approval requests electronically.

Future Activities:

- ***Launch the online approval process***
- ***Develop and implement policies to address: consistent application of training request and approval, quality of trainings being offered, and unethical conduct of trainers regarding Training Approval System***
- ***Increase funding for The Nevada Registry to support the increased staffing needs to implement the above policies to ensure quality of The Nevada Registry program***

Evaluation Process

History:

In 2003 the Office of Early Care and Education implemented a collaborative evaluation project for all programs funded or partially funded through the Child Care and Development Funds (CCDF) quality improvement earmarks. Through this effort, collaborating agencies defined statewide goals to ensure the most effective use of these quality improvement dollars. This effort involves assisting agencies and programs in reporting program budgets, which will increase accountability. In addition, programs will continue to collect data, which will increase understanding of program effectiveness as well as provide the OECE information for annual statewide reports.

Pacific Research Associates has designed and implemented a web-based budget reporting and data collection system. Agencies are expected to complete web-based budget reporting forms and data collection reports for each program funded or partially funded with CCDF quality dollars by August 2005. Additional technical assistance and training will be provided to participants to continue work on more consistent indicators across all programs.

Current Status:

The process to develop and implement the outcomes project is on-going and is a long-term project. At this time, program implementation (quantity) indicators have been established as

well as some outcome (quality) indicators. Contractors will submit their 2005/06 data for these indicators by July 31, 2006. A summary of the data collected across all programs will be completed by October 2006. In addition, the data from 2005-06 will be used to help identify common indicators that projects will collect data on in the future.

Future Activities:

- ***Begin to utilize preliminary budget expenditures and data collected to assess each program's effectiveness and fiscal accountability***
- ***To continue work with Pacific Research Associates to help identify additional indicators***
- To develop measurement tools needed for data collection
- To collect data electronically over the internet

ELEMENT 5 – ACCESS AND OUTREACH

Online Database of Training and Education Opportunities, Career Development Advising, and Multiple Professional Development Delivery Methods

Current Status:

The Nevada Registry has developed a website which makes it possible for

Early Care and Education professionals to have access to an online calendar of statewide approved training opportunities. By visiting the online calendar, individuals are able to search for approved training by date, city, county or Core Knowledge Area. The website also features a course listing for degrees in the field of Early Care and Education offered through the Nevada System of Higher Education, additional links to community agencies, updates related to ECE and other information intended to support the professional development needs of Early Care and Education professionals.

The Registry has also created a process to assist professionals with the tracking of their completed training. Upon initial application, and upon each annual renewal thereafter, Registry participants are issued a Training Report that reflects their completed Registry-approved workshops/training. The Training Report serves as a tool for verifying compliance with the training requirements of Licensing and is designed to help professionals determine which Core Knowledge Areas they have a strong knowledge base in and those in which further learning and growth is needed.

Career advisement is also offered by the Child Care Apprenticeship Program, T.E.A.C.H. Early Childhood NV and all six colleges and universities.

Distance learning courses are now being developed for easy access on the web, and many already exist. Child care training modules for self-learning are also available.

Future Activities:

- Develop a tool to assist early childhood professionals in setting goals and completing an individualized professional development plan

Public Engagement Efforts/Initiatives

Current Status:

While there have been some materials published and distributed on choosing quality child care and the Pre-K Standards, there is minimal effort made in the area of explaining quality initiatives and professional development opportunities to families on a statewide basis.

Future Activities:

- Increased public acknowledgement of accredited centers and family home providers
- Develop and distribute parent education materials explaining the importance of quality initiatives that are available to their child care provider through a coordinated effort by the Resource and Referral agencies and various community agencies

APPENDIX C: NEVADA DIVISION OF CHILD AND FAMILY SERVICES, CHILD AND ADOLESECENT STATE INFRASTRUCTURE GRANT (SIG)

ANNUAL GRANT RE-APPLICATION

PREPARED BY: Rebecca Richard-Maley, Project Director

DATE PREPARED: March 14, 2007

I. The Nevada SIG has five primary goals and related objectives:

Goal One: Nevada will develop a common vision and plan for developing an integrated and comprehensive behavioral health system across agencies

1.1: Prepare the State Consortia to develop a comprehensive and integrated plan.

1.2: Identify gaps and duplication in Nevada's behavioral health services for children.

1.3: Assess Nevada's behavioral health services funding streams and resources.

1.4: Develop a long-range plan to build an integrated and comprehensive behavioral health system for children and families in Nevada.

1.5: Ensure that the integrated system of services and supports can be sustained

Goal Two: Nevada will strengthen and streamline the interagency coordination and funding mechanisms needed to support the developing System of Care

2.1: Complete and implement the behavioral health system redesign financing plan.

2.2: Support the continued development of the mental health consortia.

2.3: Grant responsibility and flexibility to local consortia to develop effective science-based services and supports that fit their jurisdiction.

2.4: Develop and implement an ongoing process for the local and state consortia to review and correct system challenges and barriers to effective integrated services.

2.5: Develop and implement a system of communication to support the integrated behavioral health system.

2.6: Develop and implement a public engagement campaign.

Goal Three: Nevada will develop the needed service and provider infrastructure to implement the integrated and comprehensive behavioral health system

3.1: Support the development of the community-based infrastructure needed to provide the identified continuum of services and supports.

3.2: Develop and implement a universal screening process for young children and youth

3.3: Implement a comprehensive suicide prevention program for youth

3.4: Improve access to rural services.

3.5: Improve the cultural proficiency of services and supports

3.6: Support the expansion of family-to-family supports.

3.7: Expand access to fidelity wraparound process (integrated service coordination).

Goal Four: Nevada will develop the infrastructure to support continuing development of the work force for the integrated and comprehensive behavioral health system

4.1: Provide resources and incentives to continually update behavioral health staff in science-based practices.

4.2: Expand capacity and infrastructure support for a high fidelity wraparound process

4.3: Improve cultural proficiency of workforce

4.4: Develop and implement a system of strengths based professional development.

Goal Five: Nevada will strengthen the state level infrastructure for performance management and quality improvement efforts

5.1: Through policy and funding arrangements Nevada will require sufficient and consistent data to monitor outcomes for all behavioral health services.

5.2: Through policy and funding arrangements Nevada will require sufficient and consistent data to monitor behavioral health service process, quality and costs.

5.3: Use the outcome, process and cost data to assess the relative impact of different services and programs and to make decisions about future system development.

5.4: Make evaluation data available for use by consumers and stakeholders.

5.5: Disseminate lessons learned from the project within and outside the state.

Description and explanation of changes, if any, made during this budget period

The Goals and Objectives of Nevada's SIG Project remain as stated above and in the original proposal.

The Statewide Team has responsibility for the day-to-day oversight of the project. Previously defined in the initial grant work plan as the Project Team, this group of staff is now referred to as the Statewide Children's Behavioral Health Team, referenced herein as the Statewide Team. The Statewide Team meets bi-weekly to monitor the day-to-day activities necessary to meet the goals and objectives of the Project. The Statewide Team includes project staff and consultants, key Division of Child and Family Services (DCFS) mental health staff, the statewide parent network coordinator, and the University of Nevada at Las Vegas (UNLV) program evaluation staff.

The Project Location relocated to Reno, Nevada in August 2006. The current project address is:

Division of Child and Family Services

Northern Nevada Child and Adolescent Services

2655 Enterprise Road

Reno, Nevada 89512

Phone: (775) 688-1645

Ext. 307, Rebecca Richard-Maley, Project Director

Ext. 315, Grace Lomascola, Administrative Assistant

Fax: (775) 688-1647

E-mail: brichard-maley@dcfs.state.nv.us

Organizational Structure for the project remains essentially unchanged, except for the hiring of two new project staff and the reassignment of key staff.

Kristen Rivas commenced as the Performance Management Coordinator Manager on January 2, 2007. Mrs. Rivas has a Masters of Science Degree and is a licensed Alcohol and Drug Abuse Counselor who previously worked for the single state authority in Nevada for Substance Abuse Treatment and Prevention. Grace Lomascola was hired as the Administrative Assistant to the grant in November 2006. (Reference Appendix A, Staff Resumes)

Name	Role	Qualifications
Fernando Serrano	Acting State Consortium Chair	DCFS Administrator
Patricia Merrifield	Principal Investigator	DCFS Deputy Administrator
Maria Canfield	Division of Mental Health and Developmental Services Liaison	Substance Abuse Administrator
Mary Wherry	Health Care and Financing Liaison	DHCFP Deputy Administrator
Karen Taycher	Executive Director, Nevada Parents Encouraging Parents	Parent of Youth w/ Disabilities
Karen Taycher	Clark County Children's Mental Health Consortium Chair	Executive Director, Nevada Parents Encouraging Parents
Pam Becker	Washoe County Children's Mental Health Consortium Chair	QA Specialist for not-for profit child and family agency
Ruth Aberasturi	Rural Nevada Children's Mental Health Consortium Chair	Retired Educator and Principal
Becky Richard-Maley	Grant Project Director	Clinical Program Planner III.
Susan L Mears	DCFS Children's Mental Health Quality Assurance and Improvement Manager	Clinical Program Planner III.
Kristen Rivas	Performance Mgt Coordinator	Clinical Program Planner II

Robin Landry	Workforce Development Coordinator	Clinical Program Planner I
Sharon James	Cultural Community Liaison	Social Services Specialist III
Christa Peterson	Consultant	Psychologist
Ramona Brinson	Principal Evaluator	University Professor
Kathy Hughes	State Parent Coordinator-	Parent of Youth w/ Disabilities
Grace Lomascola	Administrative Assistant	Two years of experience
Gretchen Carlson	Fiscal Funding Coordinator	Account Specialist
Matt Gyger	Evaluation Coordinator	Director of University Research Center

III. Description of activities and accomplishments related to the goals and objectives of the grant.

Goal 1: Nevada will develop a common vision and plan for developing an integrated and comprehensive behavioral health system across agencies

1.1: Prepare the State Consortia to develop a comprehensive and integrated plan.

A short term Steering Committee was proposed to provide leadership and oversight to the transformation of children's mental health treatment services during Grant Years 1 and 2. In June 2005, the Transforming Children's Mental Health Treatment Services in Nevada Steering Committee, herein referenced as the Steering Committee, met for the first time.

Under the leadership of Michael Willden, Director of the State of Nevada Department of Health and Human Services, the Steering Committee evolved into the Statewide Children's Behavioral Health Consortium during Grant Year 3. The formation of the Consortium was guided by a memorandum of agreement drafted in Grant Year 2. The Statewide Consortium broadened the membership to include adding the chairs of the three regional mental health consortia, tribal representation and additional parent representation, incorporated the suggestions of the former steering committee and the participants of the Children's Mental Health Academy. In September 2006, DCFS secured the technical assistance services of Suganya Sockalingham, international consultant. Ms. Sockalingam is recognized for her work in cultural diversity and system of care development. Ms. Sockalingam is providing technical assistance and facilitation to the Nevada Children's Behavioral Health Consortium, technical assistance for the planning and development of statewide cultural diversity and technical assistance to the Nevada Children's Behavioral Health Consortium workgroup on Strategic Planning.

The statewide Consortium convened for the first time in October 2006 to discuss its by-laws and governance. In addition, a recommendation has been made to Mr. Willden regarding the creation of a group of high-level state and county officials who have the capacity to mobilize resources and funding to direct the work of furthering system of care implementation statewide. (Reference Appendix B, Nevada Children's Behavioral Health Consortium Membership and Minutes)

The statewide Consortium convened three work groups at their second meeting in January 2007. They established workgroups for Collaboration, Strategic Planning, and Financing.

The workgroups are charged with meeting and developing draft work charters prior to the third meeting of the Consortium in March 2007. The statewide Team will support the work of the statewide Consortium.

In order to facilitate planning for youths with substance abuse and co-occurring disorders, representatives from the State Substance Abuse Authority and substance abuse providers were added to the statewide Consortium.

1.2 Identify gaps and duplication in Nevada's behavioral health services for children.

Per Nevada Revised Statutes 433B.335, the three regional consortia are to present recommended plans for the provision of mental health services to emotionally disturbed children in their jurisdictions. Each plan must include an assessment of needs and recommendations to include services, eligibility and funding mechanisms. The plans are submitted to the Director of the Department of Health and Human Services. The recommendations of the three consortia annual plans guided the development of the Governor's Proposed Budget for the next biennium. The suggestions this biennium included the addition of the intake positions for state children's mental health programs in Washoe County to provide single points of access and information services to families and stakeholders (mirroring existing services in Clark County), expansion of Early Childhood Mental Health day treatment services and funding to implement mobile crisis intervention services. The Legislature convened on February 5, 2007. During Legislative Hearings on the Governor's Proposed Children's Mental Health Budget, the local consortia were credited for bringing children's mental health needs and recommendations to the attention of the executive and legislative branches.

In preparation for the work of the statewide Consortium, the Statewide Team conducted an assessment of all recommendations made by the three regional mental health consortia. The Statewide Team reviewed the findings of the local consortia over the last five years. Service gaps, needs were synthesized and recommendations were cross walked in a grid format.

The Statewide Team has begun to assess the needs of the system for greater cultural competence. In October of 2006, DCFS completed an assessment of the Limited-English Proficient population in the rural region of Nevada. For purposes of the assessment DCFS used US Census Bureau data; State of Nevada Department of Education data; DCFS local office Limited-English Proficiency files; information collected from the local office staff and the Family Resource Centers in which language assistance services are provided. Findings from the assessment included the lack of qualified interpreters, the lack of qualified translators and the need for language assistance services for Spanish speaking individuals to gain meaningful access to services.

The assessment was used to develop the Nevada Rural Region Summary Report of Needs. As a result of this assessment DCFS identified gaps in its language access services. Subsequently DCFS took steps to augment procedures and practices to ensure that Limited-English Proficient individuals and/or families have effective communication access to services.

The Rural Region Language Assistance Plan and supporting documents were submitted to the Office for Civil Rights on January 5, 2007 for review. DCFS continues to work cooperatively with Office for Civil Rights to finalize this plan.

1.3: Assess Nevada's behavioral health services funding streams and resources.

The Statewide Consortium reviewed the Children's Behavioral Health Financing Self-Assessment by Sheila Pires and created a Financing Workgroup to assess current financing and develop future financing strategies. Ms. Pires has agreed to consult with this workgroup and recommended that a Nevada consultant familiar with in-state funding across systems also be identified. This workgroup has identified a consultant to recommend to the consortium. CA-SIG funds will support this work.

1.4: Develop a long-range plan to build an integrated and comprehensive behavioral health system for children and families in Nevada.

In preparation for the long-range planning to be initiated by the newly created Statewide Consortium, the Statewide Team held a day-long meeting with local consortia representatives and family members in April, 2006. This group of stakeholders reviewed all of the pending recommendations synthesized from the local consortia plans, the SAMHSA Policy Academy and the SIG Work (see 1.2 above). The group developed integrated, statewide goals and objectives to reflect these recommendations. These goals and objectives were approved by Michael Willden, Director of the Department of Health and Human Services. These integrated goals and objectives will be shared with the Statewide Consortium as a starting point for their Strategic Planning Workgroup.

Efforts are also underway to integrate planning efforts with those of the new governor around substance abuse treatment. The Statewide Family Network Coordinator has been in contact with one of the founders of Washoe County Safe n' Sober Foundation, a parent of a young adult with mental health and substance abuse issues about meeting with Nevada's First Lady, Mrs. Gibbons to discuss families that have children with substance abuse issues and how we can work together to help these families. Mrs. Gibbons has made substance abuse one of her priorities. No date has been set yet.

DCFS children's mental health and juvenile services staff are partnering with county juvenile services and the Substance Abuse Prevention and Treatment Agency staff to identify priority needs, plan for the use of new funding for treatment of youth with co-occurring disorders and develop requests for proposals.

1.5: Ensure that the integrated system of services and supports can be sustained

The Statewide Team supported efforts to sustain needed services and supports through the Medicaid Behavioral Health Redesign. The Redesign implemented a plan to fund Family-to-Family Support services through the Medicaid Program. After four years of hard work to becoming a Medicaid provider, Nevada PEP and system stakeholders received news that Family Support has been cut as a funded service in the Medicaid services. The Center for Medicare and Medicaid Services did not approve Nevada's Family-to-Family Support Services as requested in the State Plan Amendment for behavioral health services. As Nevada's Family Network for children's mental health care needs, Nevada PEP will use the knowledge acquired over the last four years and new technology implemented at Nevada PEP to move forward in providing Family Support Services and continue to advocate for System of Care practices throughout the state of Nevada.

The Statewide Team has worked to sustain interagency collaboration through the development of memoranda of understanding. In addition to the Memorandum of Agreement creating the statewide Consortium draft in Year 2, DCFS and the Division of Mental Health and Developmental Services finalized a Memorandum of Understanding

(MOU) between the two agencies in the fall of 2006. The MOU was presented to staff in both Clark and Washoe Counties by the Division administrators in November 2006. The MOU formalized the understanding that both agencies will cooperate to assure that optimal services are provided to children and families and sets parameters for referrals between the Divisions for youth dually diagnosed with mental health disorders and developmental disabilities and for youth transitioning from youth to adult mental health services. (Reference Appendix C, Memorandum of Understanding between Divisions of Mental Health and Developmental Services and Child and Family Services)

Goal 2: Nevada will strengthen and streamline the interagency coordination and funding mechanisms needed to support the developing System of Care

2.1: Complete and implement the behavioral health system redesign financing plan.

In Grant Year 1, the Interim Steering Committee was created to develop and implement the Medicaid Redesign Plan. That year, the Nevada Legislature approved the funding to implement the first components of the Plan, including the expansion of behavioral health clinics for Medicaid recipients to private providers, and funding for additional community-based services such family-to-support services and mobile crisis services and changes in the authorization process for Medicaid Rehabilitation Services transferring responsibility from state agencies to private QIO-like contractor. In Grant Year 2, the Steering Committee finalized the required changes to the Medicaid State Plan and Medicaid Policy Manual. These changes were implemented in January, 2006.

In Grant Year 3 (December, 2006), the Federal Center for Medicare and Medicaid Services disapproved Nevada's State Plan amendments written to implement the behavioral health redesign. The newly created statewide Consortium is monitoring and supporting Nevada Medicaid's efforts to rectify this situation. The statewide Consortium's Financing Workgroup will be examining alternative funding and financing strategies to support children's behavioral health services in the developing system of care.

2.2: Support the continued development of the mental health consortia.

In order to strengthen and streamline interagency coordination, the Statewide Team continues to support the work of the three regional consortia. In November 2005, a subgrant was established for stakeholder support. This subgrant provides stipends for parent travel and participation in meetings and events, financial support for parents who need child care in order to attend events, financial support for parents to attend trainings, and support for the Consortia activities. Each Consortium is provided an operational budget to support its activities. The subgrant for the support of the work of the Consortia was renewed through September 30, 2007.

The three Consortia conduct community-based assessments and develop annual plans addressing the behavioral health needs of children and families in their communities. This Grant Year, the Consortia provided valued feedback for strategic planning and budget development for DCFS. All of the regional consortia have expanded their membership to include tribal representation and substance abuse providers. The Washoe County Consortium is facilitating the formation of a youth group. The Rural Consortium conducted a strategic planning meeting in August 2006 that increased stakeholder input and membership from all of rural Nevada, including the increase of a strong parent voice. The Clark Consortium distributed materials to local emergency rooms and schools, sponsored activities,

to include a press conference to promote Children's Mental Health Awareness Day, provided education to local behavioral health providers, and supported the expansion of school-based behavioral health screenings and services.

These are just some of the highlights and accomplishments of the Consortia. Their complete annual plans can be assessed on the Nevada Department of Health and Human Services and the Division of Child and Family Services websites. These plans were provided to the Nevada State Legislature.

2.3: Grant responsibility and flexibility to local consortia to develop effective science-based services and supports that fit their jurisdiction.

This objective was not addressed in Year 3.

2.4: Develop and implement an ongoing process for the local and state consortia to review and correct system challenges and barriers to effective integrated services.

The strategy to address this objective is the formation of the statewide Consortium with membership of all three regional consortia chairs.

2.5 Develop and implement a system of communication to support the integrated behavioral health system.

The Statewide Team has been working to ensure that all key stakeholders are represented on the Statewide Consortium and the three local consortia

The team's Cultural Liaison facilitated the process for inclusion of representatives of cultural groups to participate at the state and regional consortia level.

Meetings of all statewide and regional consortia have been held in accordance with the Nevada Open Meeting Law. Minutes of the meetings are available to key stakeholders and consumers. During Year 3, all of the regional consortia plans (2002-2006) were posted on the Department of Health and Human Services and the Division of Child and Family Services' websites.

Nevada PEP has established a mentoring process for the parents and families who assist with the CA-SIG Project. The mentoring process involves extensive training whereby parents are educated about the nature of meetings, their role and are provided a mechanism to assess the extent to which they feel they have a "voice" and their contributions are valued.

2.6 Develop and implement a public engagement campaign.

The SIG Project is supporting the efforts of the Clark County Children's Mental Health Consortium (CCCMHC) to develop and implement a public engagement campaign to reduce public stigma around children's behavioral health problems and increase public support for children's behavioral health services.

The CCCMHC formed a Workgroup to develop and implement a public engagement campaign to increase awareness of children's mental health issues. This campaign will serve as a prototype for the statewide effort.

The Workgroup's key partners in the campaign are Nevada's Garrett Lee Smith Youth Suicide Prevention Project, the State Office of Suicide Prevention, the Southern Nevada Health District and the Division of Child and Family Services. Other Workgroup participants include representatives from Nevada Parents Encouraging Parents, the Clark

County School District, local chapter of the American Academy of Child and Adolescent Psychiatry, other local mental health providers and the Children's Advocacy Alliance.

The CCCMHC has developed a multifaceted public engagement campaign plan which was launched with a news conference on National Children's Mental Health Awareness Day. Legislators, Parents, and Consortium members spoke to the press and media about the challenges that families face in order to access behavioral health services for their children. The Clark County Board of Commissioners issued a proclamation acknowledging the importance of children's behavioral health and recognizing the efforts of the CCCMHC. A family member was interviewed by Henderson and Las Vegas newspapers during which she shared her first hand knowledge as a parent of a child with a mental illness. A Nevada PEP Family Specialist who speaks Spanish was available at the press conference to explain in Spanish the purpose of the press conference and to highlight for families where to find help. Her story was aired on a local Spanish television station.

The Workgroup found that one of the key barriers to improving children's behavioral health services is the stigma associated with children's behavioral health problems. The Workgroup studied the results of a large survey recently conducted nationally by HarrisInteractive in collaboration with the Portland State University Children's Mental Health Research and Training Center. This study confirmed that both adults and teenagers have less understanding and more negative perceptions of youths with behavioral health problems as opposed to those with physical health problems. The Workgroup identified two goals of the Public Engagement Campaign: (1) increase public awareness about the prevalence and signs of children's mental health problems; and (2) encourage parents and youth to engage in early help-seeking behavior as needed.

The CCCMHC created a brochure to help parents recognize the signs of mental health problems and know how and where to ask for help. The brochure is available in English and Spanish and was distributed to parents through the school district, health district, local hospitals and fire departments. With the assistance of Matteson Media, Inc., the CCCMHC Workgroup is producing a series of public service announcements that began airing on television and radio beginning in December, 2006. The stakeholders on this Workgroup actively participate in the development of the public service announcements. In addition, focus groups of parents and/or youth involved in behavioral health issues are being utilized to develop the scripts and the messages for these public service announcements.

During December 2006, the first public service announcement was produced, edited, finalized and distributed to several local television stations for airing. This PSA was targeted toward caregivers of children with suspected behavioral health problems. The 30-second commercial was aired during the last week of December, 2006 (12/25-12/31/06) and the second week of January, 2007 (1/8/07-1/14/07) on the following television stations: Fox 5 TV – 60 spots over the two weeks; CBS TV 8 – 75 spots over the two weeks; eight Cable Stations (AEN, LIFETIME, FX, TBSC, TNT, USA, CRT and ENT) for a total of 218 spots over the two weeks.

An evaluation has been conducted to assess the effectiveness of this initial media campaign. Over 100 call-in responses to the commercial have been tracked and callers are being linked with services and/or sent information about children's mental health. A questionnaire has been sent to callers to evaluate the effectiveness of the public service announcement and the

helpfulness of the information/assistance provided. The results of this specific analysis are being compiled.

This first public service announcement is available on the Southern Nevada Health District Website. A news story on the public education campaign was also aired on a local television station (Channel Five) on January 11, 2007. Karen Taycher, a representative of Nevada Parents Encouraging Parents, Hilary Westrom, a children's advocate, and a parent of two seriously emotionally disturbed young children were interviewed as part of the story.

The Workgroup is collaborating with the GLS Youth Suicide Prevention Project to produce a second public service announcement to be used in the campaign. This public service announcement will be targeted toward teens. The Workgroup has reviewed a preliminary script and story board for this youth-focused commercial. A subcommittee of the Workgroup will convene a focus group of youths to review and finalize the script and storyboard.

In conjunction with the media campaign that began in December, the CCCMHC contacted 800 local primary care physicians and pediatricians in January, 2007 to offer brochures for parents, posters for use in their clinics, and referral information. To date, nearly 50 physicians have expressed interest in the public education campaign and have been sent materials.

The CCCMHC's Public Engagement Campaign is being supported by the Nevada CA-SIG Project, the Community Mental Health Services Block Grant and GLS Youth Suicide Prevention Project. The Consortium is also seeking funding from local businesses and other private foundations to support this campaign. The Workgroup will submit a grant proposal to the American Psychiatric Foundation. The Workgroup has been exploring the possibility of partnering with private industry to support the campaign. At least one major corporation has expressed interest in partnering with the CCMHC in its public education campaign.

A public education toolkit will be developed in the coming grant year to disseminate the campaign to other jurisdictions in the state.

The Workgroup continues to collaborate with a concerned citizen experienced in influencing legislators to develop materials and strategies for educating legislators and other decision-makers about children's mental health issues. Materials for legislators have been developed to highlight the state and community challenges around behavioral health services to Nevada's children.

Goal 3: Nevada will develop the needed service and provider infrastructure to implement the integrated and comprehensive behavioral health system

3.1: Support the development of the community-based infrastructure needed to provide the identified continuum of services and supports.

The goals of the Medicaid Behavioral Health Redesign were to expand services and access to mental health treatment through the establishment of behavioral health community networks. Through the interim Steering Committee, these networks were developed and implemented in Grant Years 1 and 2. In January, 2006, Medicaid began enrolling these regional networks.

During this grant year, the number of networks has continued to increase across the state. Twelve new networks in Nevada have enrolled with Medicaid since December 2005.

The Statewide Team has also been working to improve the community-based infrastructure to increase access to services for minorities.

As a first step, a Rural Region Language Assistance Plan to ensure that Limited-English Proficient individuals and/or families gain meaningful access to services. The process for Limited-English Proficient individuals to receive timely language assistance, which means provision of necessary oral and written language services through use of qualified interpreters and/or qualified translators is outlined in the plan. The next step is training for staff to gain full understanding of the procedures to assess language needs then to provide culturally relevant language assistance services to the individual and/or family.

Through use of the language access services, the Limited-English Proficient individual and/or family has an equal opportunity to participate fully in the services, activities, programs or other benefits administered by DCFS.

Nevada plans to use the language assistance plan as a template to improve linguistic competence in the state and to develop meaningful access to mental health services for Limited-English Proficient individuals. (Reference Rural Region Language Assistance Plan).

The 2005 Legislature approved a child and adolescent psychiatry residency program at the University of Nevada, Reno. During this grant year, the Statewide Team has provided fiscal and program support in implementing this program which is a collaboration between the University of Nevada, Reno and the Division of Child and Family Services.

3.2: Develop and implement a universal screening process for young children and youth

A Standardized Assessment Workgroup was formed to develop a standardized assessment tool that would be used by child serving agencies that conduct mental health assessments. The goal is to have one assessment tool that will be used and shared among many agencies. Children and their families would have an assessment completed at one agency and it would travel with them if they sought services at other child serving agencies. Participating agencies span across child welfare, mental health and juvenile justice.

The Standardized Assessment Workgroup has developed an assessment tool that is being piloted by several agencies. When the pilot is completed participants will provide feedback and revisions will be made to the tool. The Workgroup is developing draft policies, procedures, and a memorandum of understanding (MOU) that will describe how the Standardized Assessment is used and shared among agencies. Agencies will formally agree to use the standardized assessment tool through the MOU. The Standardized Assessment will be presented to the Nevada Children's Behavioral Health Consortium for final decisions regarding adoption and implementation.

3.3: Implement a comprehensive suicide prevention program for youth

DCFS was awarded a SAMHSA Garrett Lee Smith Youth Suicide Prevention Grant in late September of 2005. DCFS sub granted the award to the Nevada Department of Health and Human Services where the statewide Suicide Prevention Office is located. DCFS maintains fiscal and legal responsibility for the Youth Suicide Prevention grant. The

Youth Suicide Prevention grant builds upon existing efforts in the Clark County School District in using the Columbia TeenScreen in 9th grade health classes. Goals of the Youth Suicide Prevention grant are to expand the TeenScreen from ten to twenty schools, to implement gatekeeper training, to develop a statewide suicide prevention plan and to evaluate the impact of these services and supports. Efforts continue to coordinate and co-fund related activities between the Youth Suicide Prevention Grant and the CA-SIG.

After a year of reviewing the existing suicide prevention efforts in Clark County, the GLS Project implemented an improved suicide prevention screening and intervention program in the Clark County Schools in October, 2006. The new program adheres more closely to the TeenScreen model and includes a quality assurance component. Through the efforts of Nevada PEP, families are also working with the program to better engage families and enhance the effectiveness of the program. A local process evaluation conducted by the University of Nevada, Las Vegas is underway to help standardize the model for potential dissemination statewide.

3.4: Improve access to rural services.

The Department of Health and Human Services is working closely with the new Governor and the Legislature to develop and implement a plan for the recruitment and retention of behavioral health professionals in rural communities targeted for the 2008-2009 biennium. DCFS staff are actively involved in this strategic planning.

3.5: Improve the cultural proficiency of services and supports

The Statewide Team has supported the development of a language assistance plan for the Rural Region which will be used as a template for statewide planning and implemented. Meaningful access to care is provided through a coordinated effort of existing resources including bilingual staff, translators and interpreters that have been identified in the Rural Region Language Assistance Plan.

Definitions relating to Limited-English proficiency have been deployed throughout DCFS services in the Rural Region.

Limited-English Proficient (LEP) means individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English in a manner that permits them to communicate effectively with DCFS.

Language Assistance shall mean all oral and written language services needed to assist individuals with LEP to communicate effectively with DCFS' staff. DCFS will provide individuals that are deemed LEP with meaningful access to and an equal opportunity to participate.

DCFS efforts were supported by the Nevada Purchasing Division's contracts with five national entities to provide language and linguistic services to Nevada's agencies. The Cultural Liaison analyzed the contracts and provided a comparison of the linguistic services offered by each company.

A translation protocol has been developed for identification of vital documents and for quality assurance purposes. A sub grant was developed and awarded to a local translator to provide quality translation services to DCFS. The translation of child welfare vital documents into the Spanish language is complete and the documents have been deployed throughout the local offices.

Policy and procedure for the implementation of the comprehensive Language Assistance Plan has been approved by the Division of Child and Family Services Administration. The policy includes a formal procedure for grievances and notification of civil rights to LEP individuals.

The Cultural Liaison coordinated LEP training on September 25, 2006 which was provided by the Office for Civil Rights. The training for the Rural Region DCFS Managers included Title VI requirements, the review and OCR findings, the proposed resolution agreement and federal policies. Further, the importance of meaningful access to services for limited-English proficient individuals through signage, policies, procedures and documentation of primary language was conveyed to these newly assigned Language Assistance Coordinators during the initial training. The local office Language Assistance Coordinators are responsible for implementation of the plan and the provision of language assistance services for LEP individuals in the rural region of Nevada.

The Statewide Team has initiated the protocol for quality and accurate translation of vital documents into the Spanish language which supports the limited-English proficient individual and/or family to fully understand their rights and responsibilities toward children in care.

3.6: Support the expansion of family-to-family supports.

Nevada PEP (Parents Encouraging Parents) is the statewide parent partner in system development. Nevada PEP continues to inspire families to focus attention on systems change. Nevada PEP provides families with encouragement, inspiration and desire to be involved with systems change. DCFS supports the work of Nevada PEP through subgrants and contracts from the CA-SIG, Community Mental Health Services Block Grant and the DCFS state general funds budget. Approximately $385,000 annually is made available to Nevada PEP from DCFS.

The Rural Consortium has seen an increase in family participation in the monthly meetings as well as the Retreat held in June. These families are voicing the struggles they have endured trying to access mental health services for their children at the Rural Clinics.

The Washoe County Consortium also saw an increase in family participation in their Family Involvement Workgroup where they compiled a list of positives and barriers they have encountered when trying to access mental health services from different agencies. This document was submitted to the Consortium to be part of their annual plan.

The CA-SIG funds the activities of the Statewide Family Network Coordinator. The Statewide Family Network Coordinator is a member of Nevada PEP, a parent of two children with co-occurring disorders and is a representative to the Mental Health Planning and Advisory Council (MHPAC).

The Statewide Family Network Coordinator and a parent of a child with SED, both members of the Mental Health Planning and Advisory Council attended the Joint Conference on Mental Health Block Grant and National Conference on Mental Health Statistics: *Promoting Recovery Through Transformation: Integrating Consumers and Families with Planning and Data.*

Nevada PEP provides family support groups for family members that have children with SED in the Washoe County, Clark County and Rural areas. These support groups give family

members an opportunity to connect with other families with similar experiences, develop new supportive relationships and share information.

Nevada PEP became an authorized Medicaid Provider as of July 1, 2006. As of January 1, 2007 Family to Family Support Services was removed from the Nevada Medicaid covered services. Nevada PEP will continue to provide Family-to-Family Support Services to Medicaid families as well as families that are not Medicaid eligible but are trying to access behavioral health services for their child.

Nevada PEP serves on the Wraparound Outcomes Study planning team and will be a member of the study's advisory group which is currently being formed. During the summer of 2006, a Nevada PEP family representative took part in training activities related to the fidelity study of the Wraparound process. The representative was paired with a UNLV research assistant to conduct interviews with caregivers, program youth and wraparound facilitators.

This grant year, three family members of children with SED are members of the Nevada Children's Behavioral Health Consortium that commenced in October 2006.

This grant year Nevada PEP became a project partner for the SAMHSA funded Garrett Lee Smith Memorial Act Grant.

3.7: Expand access to fidelity wraparound process (integrated service coordination).

Wraparound in Nevada for Children and Families (WIN) is the statewide program for wraparound service process for children in the custody of public child welfare agencies and their families. The program was created and funded in the 2001 Special Legislative Session, and is closely reviewed and monitored by the Nevada Legislature. The program serves approximately 500 children per day statewide. The initial design of the program was to staff the program through contract staff. The program experienced a high staff turnover. DCFS recruited and trained WIN staff, which resulted in their leaving for permanent jobs that offered more security and benefits. Program stabilization and consistency for families became challenging. The 2005 Nevada Legislature recognized the importance of WIN, and created funding to convert the contract positions to permanent state positions. As a result, 66 state positions were created..

DCFS continues to utilize consultation from Vroon VanDenberg to assist with furthering the development of statewide wraparound practices. A supervisory curriculum has been developed with Vroon VanDenberg and is currently being implemented. The Nevada PEP Director of Programs and Services participated in Wraparound Train the Trainers training and will partner with DCFS staff to train other DCFS staff in the Wraparound model statewide, provide targeted refresher trainings and provide stakeholder trainings.

Goal 4: Nevada will develop the infrastructure to support continuing development of the work force for the integrated and comprehensive behavioral health system

4.1: Provide resources and incentives to continually update behavioral health staff in science-based practices.

The Workforce Development (WFD) Coordinator developed a Workforce Development Plan, which is a comprehensive source document. A specific action plan was developed by the WFD Coordinator in January 2007. The WFD Coordinator has lead a DCFS stakeholder team in consulting with several sites nationally which have developed and implemented organizational readiness strategies to support the implementation of various WFD initiatives,

including evidence based practices. The WFD Coordinator is developing an action plan to support organizational readiness and culture change management factors in order to implement and further support WFD activities, including professional development initiatives, for science based practices. It is expected that the organizational readiness action plan will be implemented in the third quarter of the CA-SIG year 3. The organizational readiness initiative will also drive the development and implementation of other WFD activities including professional development including training methodologies around science and evidence based practices, worker retention, a coaching model of clinical supervision, team building, and workforce supports.

During this grant year, the University of Nevada, Las Vegas will complete a workforce needs assessment that will include an assessment of organizational readiness for evidence-based practices and an assessment of cultural competency strengths and needs. In order to ensure that the Workforce Development Plan includes strategies to improve services to youths with co-occurring disorders, the Statewide Team has engaged the University of Nevada, Reno's Center for Applied Substance Abuse Treatment Program. Once the needs assessment is completed, CASAT will assist in the development of training modules for this target population.

The WFD Coordinator has facilitated a workgroup of DCFS stakeholders in consultation with the Academy of Child and Adolescent Psychiatry (ACAP) to develop and implement a Training of Trainers model to build workforce capacity to support the use of the Child and Adolescent Services Intensity Instrument (CASII) as one methodology by which SED determinations are made for Medicaid funding purposes and service provision. The training plan has been drafted and submitted for approval. It is expected that the training plan will be implemented no later than the end of the third quarter of the CA-SIG year 3. Nevada is currently waiting to implement this initiative until such time as the ACAP finalizes their revision of the CASII manual. This initiative will build workforce capacity statewide in the use of this science based tool and methodology. In addition, there are several CASII trainers statewide who have continued to provide ongoing training for DCFS and community stakeholders, including those in Clark County, Washoe County and the 15 rural counties of the State. It is expected that with the implementation of the Training of Trainers CASII model, the training efforts will be expanded to better support best and standardized practice and workforce capacity.

The WFD Coordinator has facilitated a workgroup of DCFS stakeholders in consultation with Zero to Three and Dr. Karen Frankel, University of Colorado, School of Health Sciences to develop and implement a Training of Trainers model to build workforce capacity to support the use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R) as one methodology by which young children with mental health concerns meet the threshold for medical necessity for Medicaid funding purposes and service provision. The training plan has been implemented effective November 2006 during a two day Intensive Introductory Training in which approximately 50 professionals were trained on the tool, with the Training of Trainers group participating in the training process. The group includes partners and stakeholders from the DCFS, Nevada Health Division, Washoe County child welfare, Clark County child welfare, and the private provider community. The model includes alternate months of group supervision with Dr. Frankel and peer supervision. The DC: 0-3R Intensive Introductory Training has also been expanded to

include a second day of intensive case discussion in which the Training of Trainers group members co-facilitate the manual's diagnostic application. It is expected that this DC: 0-3R training will be completed in the fall of 2007 during a two day advanced workshop and mock training. This initiative has already started to build workforce capacity and sustainability statewide in the use of this science based tool and methodology. In addition, there are several DC: 0-3R trainers statewide who have developed and provided 'awareness training' for professionals, para-professionals and parents who need to know about the merits of early recognition of children's mental health issues for appropriate referral and intervention. It is expected that with the implementation of the Training of Trainers CASII model, the training efforts will be expanded to better support best and standardized practice and workforce capacity.

Statewide system partners are invited and encouraged to attend all DCFS- sponsored training. DCFS provides financial support to system partners to encourage their participation. Sponsored training events included the DC: 0-3R training, DC: 0-3R Training of Trainers, CASII Training, CASII Training of Trainers, CAFAS Training, CAFAS Training of Trainers, Foster Family Treatment Association Annual Meeting, Wraparound Training, Federation of Families Annual Conference, and the Leadership Academy.

Nevada PEP has many curriculums available for family members and service providers on System of Care values, Parent Mentor Training, Positive Behavior Supports, Parent Representation Orientation, Kinship Foster Care Training and other behavioral health related trainings.

Nevada PEP is finishing up a final draft of a Child Welfare Curriculum for family members. The curriculum will be used for educating families about the Child Welfare System. The intended implementation date is Spring 2007.

Nevada PEP is working on a curriculum for family members on living with a child with Serious Emotional Disturbances. The curriculum will be used for helping parents understand the emotional rollercoaster that parents could naturally encounter while raising and loving a child with Serious Emotional Disturbance. The intended implementation date is summer 2007.

Nevada PEP is in the beginning stages of a curriculum about family involvement in developing policies and laws that impact the service delivery system for families that have children with Serious Emotional Disturbances. The intended implementation date is fall 2007. Key leadership in the state has agreed to work with Nevada PEP on this curriculum.

Efforts to strengthen the workforce and enhance capacity to provide services to children with co-occurring disorders are currently being developed with the Center for Applied Substance Abuse and Technology (CASAT)/Mountain West Addiction Transfer Technology Center (ATTC) at the University of Nevada Reno. A subgrant between DCFS and CASAT will be finalized in the spring of 2007 targeting the readiness of the workforce and system partners to implement science-based practices through technology transfer application. The subgrant will also target the implementation of science-based practices for the treatment of children with co-occurring disorders.

Goal 4.2 Expand capacity and infrastructure support for a high quality wraparound process.

Nevada has already invested heavily in the use of the wraparound process. Nevada's statewide Wraparound in Nevada Program and its Neighborhood Care Center Program in Clark County have been recognized nationally for their successful outcomes implementing wraparound.

The Statewide Team is working to develop infrastructure support in all three regions for wraparound service process. Trainers have been identified in each of the three regions and there is an ongoing training schedule developed for DCFS staff. A statewide training module was developed to support sustainability of the wraparound approach. Supervision standards are being developed as part of quality management.

Wraparound supervision training will also be included in the Wraparound training module. In order to better support professional development and worker well-being, the WFD Coordinator has initiated CEU approval for this activity. The Nevada PEP Director of Programs and Services participated in Wraparound Train the Trainers training and will partner with DCFS staff to train other DCFS staff in the Wraparound model statewide.

DCFS partnered with Georgetown University and brought the Leadership Academy to Nevada in September and October 2006. DCFS coordinated with Georgetown to adapt the Leadership Academy curriculum for Nevada. Fifty statewide key leaders partnered with DCFS to attend the four-day Academy. System partners include parents; child welfare, juvenile justice, substance abuse, mental health providers; consortia members, and school districts.

4.3: Improve cultural proficiency of workforce

The Statewide Team has supported the development of a language assistance plan for DCFS in the Rural Region which will be used as a template for statewide planning and implementation. Meaningful access to care is provided through a coordinated effort of existing resources including bilingual staff, translators and interpreters that have been identified in the Rural Region Language Assistance Plan. The template of procedures will be used to develop a statewide plan for children's mental health. In addition, the Statewide Team is working with UNLV evaluators to develop a needs assessment to support the implementation and use of science based and evidence based practice for and by the workforce.

4.4: Develop and implement a system of strengths based professional development.

The Statewide Team has implemented statewide training on the CASII and the Diagnostic Classification 0-3 (DC 0-3) system for early childhood. The Statewide Team developed internal Nevada expertise for CASII training and training modules and is currently working with the Academy of Child and Adolescent Psychiatry to develop a Training of Trainers professional development plan. CASII training is provided on an ongoing basis statewide, including the training of tribal entities.

The Diagnostic Classification 0-3 (DC 0-3) training was provided to over 140 DCFS staff and community partners statewide since February 2006. The Statewide Team, in collaboration with Zero to Three and Dr. Karen Frankel, has developed and implemented a Training of Trainers professional development plan for the DC: 0-3R. Currently, there

are 10 members of this group, which includes partners from the two urban county child welfare agencies, the Nevada Division of Health, DCFS, and private provider partners.

DCFS partnered with Georgetown University and brought the Leadership Academy to Nevada in September and October 2006. DCFS coordinated with Georgetown to adapt the Leadership Academy curriculum for Nevada. Fifty statewide key leaders partnered with DCFS to attend the four-day Academy. System partners include parents; child welfare, juvenile justice, substance abuse, mental health providers; consortia members, and school districts.

DCFS in partnership with the Nevada Youth Care Providers Network created a Provider Support Team (PST) in the spring of 2006. County child welfare partners also joined the team. The focus of the team is to effect the implementation of evidenced-based practices within the provider community, and to recruit providers to Nevada. Representatives from the Provider Support Team attended the Foster Family Treatment Association annual conference in June 2006. Recruitment brochures were developed by the Team and distributed at the conference. The brochure is also posted to the DCFS website. In addition, the representatives brought back suggestions for improving practice. The Team recommended to DCFS that the implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Multidimensional Treatment Foster Care be considered as priorities.

The Statewide Team, in collaboration the PST and with our system and family partners, has consulted with Drs. Tony Mannarino and Judy Cohen from Allegheny Children's Hospital in Pittsburgh, PA about bringing TF-CBT training to Nevada. In addition, the Statewide Team, in collaboration with our system and family partners, has collaborated with 3 national sites (i.e., Harbor View Sexual Assault and Trauma Center, the State of Illinois, and the State of Massachusetts) about their implementation strategies for TF-CBT and the tasks they deployed to support organizational readiness. Nevada is currently developing action planning steps to support organizational readiness for the implementation of science-based practice(s).

Goal 5: Nevada will strengthen the state level infrastructure for performance management and quality improvement efforts

5.1: Through policy and funding arrangements Nevada will require sufficient and consistent data to monitor outcomes for all behavioral health services.

During this grant year, the DCFS Planning and Evaluation Unit has been collecting and reviewing outcome data from DCFS's children's behavioral health programs. Clinical outcomes have been measured utilizing the Child Behavior Checklist, the Child and Adolescent Functional Impairment Scale, and the Child and Adolescent Service Intensity Inventory. Functional Outcomes are also being measured, including school performance, juvenile justice contact, and level of residential care. Outcome reports will be completed by the unit this year and shared with the newly created Statewide Consortium to plan for the collection of outcome data across systems.

In addition to these efforts, DCFS completed the first statewide outcome survey of families. The pilot survey, conducted in the fall of 2006, also satisfied the evaluation requirements for the Center for Mental Health Services Community Mental Health Block Grant. The survey pilot project used modified versions of the CMHS recommended survey by Molly Brunk,

Ph.D. The project was intended to introduce the instruments and to 'road test' survey procedures, support forms, staff instruction, and identify attendant survey implementation issues. Pilot survey results will be included in the State's 06 Block Grant Implementation Report. The survey instruments were reviewed/modified by DCFS staff with extensive family member input. Spanish translations of the instruments are being finalized and will be available for next year's full survey effort.

Both families and youth were surveyed in northern and southern Nevada. The table below indicates the number of participants and indication of their satisfaction with children's mental health services.

INITIAL SURVEY NUMBERS BY SITE AND SURVEY TYPE

NNCAS	YSS-F (parent)	Positive Reporters	YSS (youth)	Positive Reporters
Main campus	34	28.1 *82.6percent*	12	10.2 *85.0percent*
Mill Street	17	14.7 *86.4percent*	27	20.4 *75.5percent*
Region Total	51	42.8 *83.9percent*	39	30.6 *78.5percent*
SNCAS				
South service site	6	5.5 *91.6percent*	0	0
North service site	17	13.3 *78.2percent*	4	3.6 *90.0percent*
West service site	1	0.7 *70.0percent*	0	0
East service site	6	5.1 *85.0percent*	1	0.9 *90.0percent*
Central service site	5	4.4 *88.0percent*	1	0.5 *50.0percent*
Region Total	35	29.0 82.9percent	6	5.0 *83.3percent*
Statewide Total	86	71.8 *83.5percent*	45	35.6 *79.1percent*

5.2: Through policy and funding arrangements Nevada will require sufficient and consistent data to monitor behavioral health service process, quality and costs.

The Statewide Team's first priority in this area has been to develop and maintain quality assessment and improvement systems for enhancing and expanding further utilization of the wraparound process in the delivery of clinical case management to children and youth with serious emotional disturbance.

During this grant year, Nevada SIG partnered with Dr. Jim Rast of Vroon VanDenberg, Dr. Eric Bruns of the University of Washington and Dr. Ramona Brinson of UNLV to implement a system of quality improvement for wraparound.

DCFS piloted a process for monitoring and improving the quality of wraparound. The goals of this initiative are to: (1) Inform high quality practice; (2) create a culture where there are quality checks and ongoing use of data; (3) Ensure a better understanding of wraparound on the part of families and providers alike; and (4) Help "make the case' for better support for wraparound implementation in Nevada.

A representative sample of approximately 80 youth and families receiving wraparound case management in Clark County were selected for this pilot process. The pilot assessment was completed in November, 2006. The overall results suggested that DCFS is generally providing quality wraparound to youths and families with serious emotional disturbance. However, specific areas needing improvement were identified by the assessment and a training plan was developed and implemented. The data also are available to be used in future policymaking (e.g., the upcoming legislative session) to make the case for continued and/or enhanced resources for wraparound. Data will also help set the stage for the "Outcomes of Wraparound in Nevada" study, sponsored by the National Institutes for Mental Health (NIMH), enrollment of families in which will begin in 2007. The data also are available to be used in future policymaking to make the case for continued and/or enhanced resources for wraparound. Data will also help set the stage for the "Outcomes of Wraparound in Nevada" study, sponsored by the National Institutes for Mental Health (NIMH), enrollment of families in which will begin in 2007 (See 5.3 below).

The Statewide Team in conjunction with DCFS's Planning and Evaluation Unit (PEU) has been implementing cross-system quality assurance activities to support the new policies established through the Medicaid Behavioral Health Redesign.

PEU conducted a pilot file review of DCFS children's mental health community-based services. The file review tool, developed by Unit staff, was based upon the new Nevada Medicaid requirements (MSM Chapter 400). (See Appendix E, Provider Review Tool and Provider Review Report) Staff reviewed 58 files. Results will be used to provide preliminary recommendations to supervisors and managers. The initial recommendations to programs will be used as a starting point for a DCFS Children's Mental Health Performance and Quality Improvement Workgroup.

The PEU along with Information Management System (IMS) staff designed a monthly performance indicators report to present to DCFS managers and supervisors with the intent of it becoming a part of an ongoing outcome management process. A Descriptive Study of all DCFS children's mental health services for SFY 06 is underway. The Descriptive Study will provide detailed information on youth served. This information can be used in planning for service delivery, training, and workforce development.

A Performance and Quality Improvement Workgroup will be formed to bring together DCFS Children's Mental Health service delivery program staff along with PEU and IMS staff to develop a continuous quality improvement plan. Program managers and staff from Early Childhood Mental Health Services, outpatient services, case management, treatment homes, residential services, and the acute hospital will participate on the workgroup to ensure that

goals are relevant and meaningful to practice. Goals and performance indicators will be developed for the agency and for each program area.

Both DCFS and Medicaid Treatment Home Providers participated in a Quality Assurance Review conducted in December 2006. The quality assurance review had two components, a file review and a youth satisfaction survey (See Appendix E, Provider Quality Assurance Review Tool, and Provider Quality Assurance Review Report. The file review form was based on requirement in Nevada Medicaid's Services Manual Chapter 400 and best practice principles. The youth satisfaction survey was based on the Youth Services Survey developed by Molly Brunk (1999).

Fifty-nine files were reviewed on children that were randomly selected from the list of treatment homes recipients in the Nevada Medicaid's Management Information System billing records. Eighteen treatment home providers participated in the quality assurance review statewide. Youth in the participating treatment homes were asked to complete the youth satisfaction survey. A total of 122 satisfaction surveys were completed.

The Treatment Home Provider Quality Assurance Review was the first phase in an ongoing quality assurance and quality improvement plan. Results from this first review were sent to all providers and individual file review reports were also sent to each participating provider. In the next phase providers will be engaged to develop a quality improvement plan.

5.3: Use the outcome, process and cost data to assess the relative impact of different services and programs and to make decisions about future system development.

The Statewide Team has been collaborating with Dr. Eric Bruns at the University of Washington and Dr. Ramona Brinson of University of Nevada, Las Vegas to conduct a three-year study of the potential impact of the Wraparound Service Model (WSM) for children and youth with serious emotional disturbance (SED) and their families in Clark County. The National Institute of Mental Health is funding a large part of this study.

The study will be implemented in Clark County in April 2007. 150 youths with serious emotional disturbance and their families will receive one of two interventions: (1) clinical case management through a high fidelity wraparound process; or (2) more traditional, high-quality clinical case management.

Using several different measures, the following research questions will be answered:

(1) Are the two interventions different with respect to intensity, satisfaction and types of direct services received?

(2) Does the wraparound process result in superior behavioral and functional outcomes?

(3) What are the relative costs of the two models?

(4) What is the relationship between wraparound fidelity and outcomes?

Because the randomized design is being used, the researchers will have the ability to compare two competing care management models. The results will be received by the children's services field as one of the first opportunities to assess the true potential of wraparound, including what outcomes occur for which young people, and what are the costs and benefits of using the wraparound process.

For Nevada, the results will present an opportunity to learn from local data how best to allocate future resources to serve this population. The study will also present an opportunity for intensive assessment of service quality for Nevada's children and families. The Outcomes of Nevada study will also present another potential of wraparound, including what outcomes occur for which young people, and what are the costs and benefits of using the wraparound process.

The local infrastructure evaluation plan to be completed by UNLV also supports the overall aim of the Nevada SIG project which is to create and sustain a local infrastructure that promotes integrated planning, financing, work force development and accountability and quality improvement. University evaluators work with the Performance Evaluation Unit (PEU), staff, managers, families, providers and other stakeholder groups to create a sustainable evaluation structure. The evaluation design pairs university evaluators and PEU staff in the completion of data collection, analysis and report writing.

Specific to determining local grant practices, UNLV is developing a stakeholder survey via Delphi rounds. The Delphi process was originally developed by the Rand Corporation and used as a practical and efficient survey approach for gathering data that are not widely available. In this evaluation design the Delphi process uses as a method to convene a panel of experts, in this case the three regional children's mental health consortia, to elicit their opinions and form a group response concerning needed children's mental health infrastructure design issues. The Delphi process produces a within-group anonymity, repeat iterations and group responses that are easily convertible to survey variables as well as offering a method in which to capture data at every service level (e.g., staff, providers, families, advisory/advocacy groups).

As previously stated, UNLV's use of the Delphi process will be the primary method to gather stakeholder communication and input in the development of the Stakeholder Survey. This survey has three main objectives: (1) determine the extent to which stakeholders believe that the infrastructure goals are appropriate and have been implemented as intended, (2) measure the extent to which stakeholders feel that they have had adequate involvement in decision making and (3) measure stakeholders level of satisfaction with infrastructure activities. This process has just begun with the first round of questions going out in March. All the consortia have participated in discussions regarding evaluation and have agreed to participate in surveys and discussion groups. Washoe County Consortium's Parent Workgroup has agreed to participate as an on-going reviewer for the process.

5.4: Make evaluation data available for use by consumers and stakeholders.

Updated information on the outcomes of wraparound research in Nevada was presented at the Annual Children's Mental Health Research and Training Conference in Tampa in March, 2006 by Dr. Eric Bruns of the University of Washington and Dr. Christa Peterson, Contractor of Nevada DCFS. An article by Drs. Bruns, Rast and Peterson, on Nevada's efforts to implement the wraparound approach was accepted for publication in the American Journal of Community Psychology. This published article will be disseminated to stakeholders to include the Statewide and three regional consortia.

5.5: Disseminate lessons learned from the project within and outside the state.

The Statewide Team participates in monthly peer-to-peer phone conferences with other CA-SIG funded states to share lessons learned from the Nevada Project. The Statewide Team also provides updates and information on the project regularly to the Statewide Consortium and the three regional consortia.

Description of Difficulties/Problems Encountered in Achieving Planned Goals and Objectives

Nevada's social service and mental health agencies statewide are experiencing difficulty with the recruitment and retention of professional and support staff in both the urban and rural areas. The rapid growth in population in Nevada has caused a disproportionate increase in negative social indicators, while careers in human services become increasingly more competitive. The State of Nevada is unable to match the salary and benefits offered by county governments and private providers in the urban areas. The significant issues regarding the recruitment and retention of staff are currently being studied across sister agencies within the Department of Health and Human Services, and children's services governing bodies and have come to the attention of the Nevada Legislature. The Governor's recommended budget includes increases for targeted mental health professional classifications to include Mental Health Counselors, Clinical Social Workers, Licensed Psychologists and Psychiatric Nurses. The Department of Health and Human Services in partnership with the Legislature is developing a strategic plan to address recruitment and retention in rural communities for consideration in the budget for the next biennium.

The implementation of the Nevada Children's Behavioral Health Consortium was delayed. The Steering Committee continued to provide focus and guidance to the project until the statewide Consortium was convened in October 2006. The Consortium met for the second time in January 2007, and will meet at the end of March 2007. As this body forms and build its structure, the extent of its governance over the goals and objectives of the CA-SIG will evolve.

WORKPLAN FOR YEAR FOUR

Table 3: Project Work Plan for Year 4 with activities and target dates

TASK	TARGET DATE
Goal One	
1.1 Prepare the Statewide Children's Behavioral Health Consortium	Completed
1.2 Complete initial integrated gaps assessment	11-01-07
1.3 Complete initial integrated financing assessment	06-01-08
1.4 Develop initial long range integrated BHS plan	01-01-08
1.5 Develop initial plan for sustainability	06-01-08
Goal Two	
2.1 Complete the behavioral health redesign financing plan	09-01-08
2.2 Grant responsibility to local consortia to develop effective services and supports that fit their jurisdiction.	07-01-08

2.3 Develop and Implement an on-going process for the local and state consortia to review and correct system barriers to effective integrated services	01-01-08
2.4 Develop and Implement Communication Plan	10-01-07
2.5 Develop and Implement Public Engagement Plan	12-01-07
Goal Three	
3.1 Continue to support the development of services and providers	On-going
3.2 Refine and Implement Universal Screening	09-30-07
3.3 Implement universal screening/Develop statewide plan for Columbia Teen Screen for suicide prevention	09-30-08
3.4 Develop & implement plan for improving rural access	09-30-08
3.5 Develop plan for improving cultural proficiency	12-01-07
3.6 Continue to support participation of family members for consortia and work groups	On-going
3.7 Expand fidelity to wraparound process	On-going
Goal Four	
4.1 Continue to provide resources and incentives to update behavioral services staff in science based practices through the development of 2 training modules.	09-30-08
4.2 Expand capacity and support for high fidelity wraparound	09-30-08
4.3 Improve cultural proficiency of workforce	09-30-08
4.4 Develop and implement a system of strengths based professional development	09-30-08
Goal Five	
5.1 Expand outcome measurement to all behavioral health providers	On-going
5.2 Expand quality assurance and quality improvement across all behavioral health services	On-going
5.3 Provide on-going reports on outcomes and fidelity	On-going
5.4 Implement plan to make data available for consumers and stakeholders	On-going

APPENDIX D: Head Start State Collaboration 2006-2010 Work Plan

STATE OF NEVADA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Head Start State Collaboration

680 S. Rock Blvd

Reno, Nevada 89502

(775) 448-5254 · Fax (775) 448-5251

Nevada Head Start State Collaboration 2006-2010 Work Plan

Revised November 2006

"Through statewide partnerships, the Nevada State Collaboration Office enhances relationships, builds systems, and promotes quality comprehensive services to meet the needs of young children and their families."

This work plan was revised during the last quarter of 2006 to reflect priorities of the HSSCO for 2007. Priority areas for 2007 appear in the first section of the plan. Longer range activities that will become future priorities appear in the back section as indicated by an extra page inserted.

Logic Model Development (LMD) Program Planning **Initiative Area: Child Care**

1. Intention & Issues	Develop a formalized agreement between Head Start and State Child Care to ensure continued wrap-around funding and better communication that is vital to Head Start grantees. Further, the need for increased data on parent outcomes will be met through developing baseline data that indicate the benefits of wrap-around funding. (i.e. Are parents more likely to maintain employment? Are children healthier? etc. as a result of receiving full-day care.)
2. Community Needs & Assets	Assets: • Semi-annual meetings for HS, child care contractors, and NV Child Care Administrator have provided an avenue for open communication and problem solving. • Based upon a verbal agreement, HS programs have been receiving child care wrap-around dollars for the last five years. Needs: • A written agreement between the HSA and State Child Care will clarify processes for eligibility and funding of child care wrap-around.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• State of Nevada Child Care is re-evaluating current practice that HS qualification equals qualification for child care dollars with regard to purpose of care and unemployment. • State of Nevada Child Care may be requiring annual income verification for eligibility, thereby changing the current practice of the provision of full day care, requiring child care co-payments for parents. • State of Nevada Child Care may change the contract ceiling for HS receipt of wrap-around dollars.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• Child Care funding will continue to be available for Nevada's HS programs. • The Child Care contractors will continue to work with HS programs to optimize Child Care funds for programs. • Semi-annual meetings will continue in order to enhance communication and problem solving.

LMD Program Implementation (Timeframe: 2006 and on-going) **Initiative Area: Child Care**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO HSA and HS grantees State Child Care Administrator Child Care Contractors	1. SCO continues to plan and facilitate semi-annual child care meetings between HS, State Child Care, and Child Care contractors. 2. Work group, SCO and State Child Care Administrator work to include language regarding child care wrap around-funding to HS programs in state child development plan and a statewide MOU.	1. Semi-annual reports of child care wrap-around expenditures generate data that track percentages of children served and dollars spent. 2. MOU between Welfare/Child Care Division and the NV HSA.	<u>Short Term</u> 1. A formalized written process insures on-going child care wrap funding for HS children. 2. HS grantees have an avenue for on-going communication and problem solving with regard to Child Care funding issues, which results in improved wrap-around services to families. <u>Long Term</u> 3. Increased access to seamless full-day care. 4. # of full day slots increase if more funding becomes available.	1. Child care is not a barrier to parents who are working, going to school, or in job training, thereby increasing parents' abilities for sustained employment.

LMD Program Planning **Initiative Area: Disabilities**

1. Intentions & Issues	Because children with disabilities do not receive seamless services in the State, the HSA would like to develop a written document with the Nevada Department of Education (NDE) that can serve as a basis for school districts throughout the state. The written document will outline activities of both NDE and HSA with regard to facilitating the development of local MOUs between school districts and HS grantees to ensure children's service provision and the transition process between school districts and HS programs.
2. Community Needs & Assets	Assets • Some HS programs have good working relationships with their local school districts regarding the provision of services to special needs children. • Some HS programs have written agreements with their local school districts for service provision and inclusion sites between HS program and elementary schools. Needs • Some HS programs need support and assistance to develop written agreements for service provision and transitions.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• The Region IX Office has stated it wants an MOU developed between the Nevada Dept of Education (NDE) and the NV HSA. • Thus far, the NDE has declined to participate in a State MOU process, but does want to work with each HS grantee and school district to develop local agreements. • Child Find partnerships with local school districts are possible.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• If individual agreements between HS programs and local school districts can be developed, the State NDE may agree to participate in developing a statewide MOU which supports the local school districts and HS programs. • A state MOU between HS and NDE can serve as a template for planning and providing services to children with disabilities.

LMD Program Implementation (Timeframe: 2006-2007 and then on-going) **Initiative Area: Disabilities**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO SCO Lead Team SCO Partnership Committee SCO Work Group Child Find Nevada School Districts Nevada Dept of Education (NDE)	1. SCO works with NDE to develop a statewide MOU and revise local MOUs.	1. 3-4 local level MOU's between HS, Child Find, and individual school districts are developed annually until each HS program, Child Find, and local school district have a written agreement. 2. State level MOU between Nevada Dept of Education (NDE) and NV HSA. 3. Baseline data is developed to track # of referrals made, # of IEP's developed, # of children receiving services, increase in #'s of children receiving service, etc. in order to determine if MOU increases services for children.	<u>Short Term</u> 1. Relationship is established and/or strengthened between Head Start programs and individual school districts. <u>Long Term</u> 2. Children and families receive all necessary services as provided under law, thereby improving quality programming. 3. Children receive seamless services through negotiated IEP's that include Head Start, school district, Child Find, parents, and other relevant parties.	1. Thorough collaboration between Head Start, Child Find, individual school districts, and NDE result in the provision of needed seamless services to children (and their families) with disabilities.

LMD Program Planning **Initiative Area: Early Childhood Comprehensive Systems (ECCS)**

1. Intentions & Issues	The HS SCO will work with the Nevada Health Division to develop the ECCS grant into a comprehensive system for service delivery. The SCO and the ECCS will work together to coordinate the work each entity does with regard to collaboration and seamless service provision so that HS and other low-income families in Nevada can benefit from an integrated service delivery system.
2. Community Needs & Assets	Assets • State and regional assessments are currently in process through work groups of the ECCS grant. • HS grantees are knowledgeable about existing resources in the community • Statewide, there is a lack of coordinated comprehensive services for young children. • The HS SCO Partnership and the ECCS task force have excellent statewide, regional, and cross-professional representation. Needs • ECCS needs to complete needs assessments, including identifying existing needs assessments, identifying assets, and identifying gaps in order to complete resource mapping.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• Health Division has confirmed funding for the next three years to implement ECCS. • Though located in Health Division, the ECCS process applies across all service systems. • Sustainability will need to be built into the plan. • Nevada is experiencing rapid population growth, particularly non-English speaking families, who need services that haven't kept pace with population growth or simply aren't available. • HS SCO has committed, in its five-year strategic plan, to working with the ECCS process to coordinate systems development.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• Three years of new funding will commence this fall, allowing for implementation of ECCS Strategic Plan. Implementation funding will run from Fall, 2005 thorough Fall, 2007. • The assumption is made that a seamless system for service provision will eventually be implemented in Nevada. • Some resource availability is going to be an on-going issue as Nevada's rapid population growth continues.

LMD Program Implementation (Timeframe: 2006-2007) **Initiative Area: Early Childhood Comprehensive Systems (ECCS)**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
ECCS Grant Advisory Committee ECCS Work Groups ECCS Coordinator Maternal Child Health Bureau Chief SCO HSA /HS grantees SCO Lead Team SCO Partnership Committee SCO Work Group Legislature – process policy changes	1. HSSCO Partnership Committee members, who are also on the ECCS task force, report back to SCO Partnership Committee on quarterly basis. 2. SCO and the work group supports the ECCS in systems development and implementation to improve service coordination within and between communities.	1. Resource map is developed by ECCS and HSSCO. 2. Quarterly reports to SCO Partnership Committee result in increased knowledge about comprehensive, seamless service delivery in Nevada. 3. Increase in the #'s of HS staff and SCO partners who are knowledgeable about ECCS process. 4. Coordinate with ECCS staff in strategic planning and plan development to finalize written plan for submission to the Feds.	<u>Short Term</u> 1. The needs of HS parents are represented in the ECCS planning process. 2. Access to available services and linkages increases for HS parents and other low-income families. <u>Long Term</u> 3. Service delivery improves and services are not duplicative, thereby freeing up funding to serve increased numbers.	1. Families have access to comprehensive seamless services to promote optimum childhood and family development. 2. Services in Nevada are integrated.

LMD Program Planning **Initiative Area: Early Childhood Professional Development**

1. Intentions & Issues	Nevada Head Start Programs will increase the percentage of teachers with degrees because the quality of ECE is increased when degreed teachers are in the classroom. Although progress has been made toward reaching the Performance Standard that a minimum of 50percent of HS teachers have at least an AA, Nevada HS programs need support to continue the trend of meeting the requirement. In 2004, PIR data indicated that 24percent of Nevada HS teachers had an AA degree or above, while according to 2005 PIR data, 45percent of HS teachers statewide had an AA degree or above. Perhaps more importantly, the percentage of HS teachers with AA degrees or above varies across programs and even within programs. EHS programs appear to face the greatest challenge in meeting this standard. While the SCO and HSA are addressing this situation, and state CCDF quality dollars are being used to support scholarship programs such as Apprenticeship and TEACH programs, the fact remains that there is still limited funding to support professional development, and there is currently no funding to support increased salaries as more HS teachers earn higher education degrees in Nevada. The pattern has been that HS teachers, upon attaining degrees, leave HS programs for better paying employment. An additional issue is the need to develop bilingual and culturally competent staff to work with HS children and families.
2. Community Needs & Assets	Assets • Have university/college system in state. • Have scholarships available–OECE, TEACH, Apprenticeship, etc. • Have distance education capability in state. Needs • No accessibility to web classes from some locations in state. • Access to classes on campuses an issue in some areas of state. • Only 7percent of Head Start teachers currently enrolled in ECE degree programs. • PIR data indicates decline in percent of degrees for HS teachers. • Funding to support degree attainment and higher salaries upon degree attainment. • While sufficient classes have been developed to attain a web-based degree in ECE, there is no process for web-based or on-site practicum to be able to finalize an ECE AA in most parts of the state.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• Turnover an issue as degreed teachers have better paying options elsewhere, so often leave HS programs upon attaining degrees. • Turnover is an issue as many teachers cannot afford to stay in field because they don't earn a living wage. • Potential that Federal education requirements will change, increasing percent of required AA's and BA's. • Lack of practicum completion is a barrier to ECE degreed teachers. • Higher education requirements are an unfunded mandate.
5. Strategies	See: Program Implementation Matrix

6. Assumptions	• CCDF/Child Care Quality dollars will continue to fund activities to increase teacher education. • HS programs will support teachers in furthering education requirements. • Higher education will continue to support teacher degrees through flexible approaches for working students.

LMD Program Implementation (Timeframe: 2006-2010) **Initiative Area: Early Childhood Prof Development**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO SCO Lead Team SCO Partnership Committee SCO Work Group HSA and HS grantees HS T & TA funds to support class attendance. Scholarship Programs: TEACH OECE Apprenticeship, etc. NSHE (formerly UCCSN)	1. Workgroup reviews, integrates, and summarizes PIR data regarding teacher qualifications across all Nevada HS programs. 2. Work group presents summarized teacher qualification data to Lead Team and Partnership Committee. 3. State Pre-Kindergarten, Nevada Registry and HS teacher qualification data is compared to determine trends and develop priorities and action steps for increasing teacher qualifications. 4. The number of Head Start teachers participating in formal education support	1. A data report tracks #'s of teachers enrolled in early childhood education classes, #'s of teachers in scholarship programs, #'s of higher education early childhood education credits completed by teachers, etc. 2. A report addressing salary and higher education issues, with an additional focus on bi-lingual and cultural competency needs, details how many teachers leave HS programs when degrees are complete, and identifies strategies to increase retention.	<u>Short Term</u> 1. Increase number of HS teachers participating in Apprenticeship, TEACH, and the Nevada Registry. 2. Increased percent and numbers of teachers in ECE degree programs. 3. Increased percent and # of higher education credits HS teachers complete each semester. 4. Increased accessibility to higher ed ECE degree-based classes. <u>Long Term</u> 5. Increased # of HS teachers with AA degrees. 6. Increase retention of Head Start teachers.	1. Improved quality in Head Start programs resulting from more teachers with higher ed degrees in ECE. 2. Improved quality education for Head Start children and their families.

Resources	Activities	Outputs	Short- & Long-term Outcomes	Impact
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
	programs is established. 5. Partnership Committee determines how to support teachers in taking advantage of current education opportunities. 6. Inform partnership about needs of HS teachers to access higher education funding. 7. Identify barriers to individuals entering the field, teachers completing higher education degrees, and develop strategies to address the issues. 8. Work with all NSHE institutions and HS grantees to facilitate partnerships that will support HS teachers in attaining degrees.			

LMD Program Planning **Initiative Area: Health**

1. Intentions & Issues	HS will establish partnerships to facilitate receipt of services, including partnerships with the State Health Division and, ultimately, the Early Childhood Comprehensive Systems (ECCS) process in order to insure HS children access the medical, mental health, and dental services that they need (based on data gathered during health screenings). Further, a plan to address classroom behavior issues will be developed.
2. Community Needs & Assets	Assets • ECCS process completing statewide needs assessment and resource mapping. • HS PIR data indicates levels of need regarding various health components. • The State Oral Health Survey indicates levels of need. • Medicaid program is available to children and families up to 133percent of poverty. • Nevada Check Up/Covering Kids is available to children up to 200percent of poverty, which could include services for HS special needs children who are over-income. • Immunization data exists for all HS children. Needs • Enrollment in Medicaid and Nevada Check up is low and access to services is minimal. • Mental Health services currently minimal. In some parts of the state, screening processes to identify children needing MH services need improvement. • Nevada needs more doctors who accept Medicaid and Nevada Check Up. • Only 30percent of HS families receive WIC. • 2004 PIR data indicates that only 44percent of HS children needing medical services are receiving services. • 2004 PIR data indicates that only 55percent of HS children needing dental services are receiving services.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• Covering Kids program is available and under-enrolled. • The current Governor's budget increases mental health spending. • Increasing Nevada population is outpacing the availability of doctors and dentists. • Many providers do not accept Medicaid or Check Up. • Reimbursement rates are too low and very slow in being processed. • Challenging behaviors in classroom affect kindergarten transition, staff retention, and classroom environment.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• There is much activity regarding health issues in Nevada. HS grantees and the HS SCO will participate in the development of the ECCS process and will keep abreast of health funding changes. • Increasing the # of children enrolled in Medicaid and Nevada Check up will increase the number of children receiving medical, mental health, and dental services.

LMD Program Implementation (Timeframe: 2007 and on-going) **Initiative Area: Health**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO SCO Lead Team SCO Partnership Committee SCO Work Group State Health Division Welfare ECCS DCFS School Districts	1. Cross-training among HS, Health, and Welfare regarding program services, including how to make correct referrals for enrollment in Medicaid and Nevada Check Up. 2. Partner with the Health Division and Health Care Finance and Policy to assure that Head Start is at the table for ongoing conversations to meet the needs of health needs of low-income children and their families. 3. Establish work group to assess mental health service needs, including challenging behaviors, and strategize to meet identified needs. 4. Continue working with the State Oral Health	1. Increased percent of children enrolled in Medicaid and Nevada Check Up. 2. Report that tracks percentage changes relative to baseline data for: children enrolled in paid health insurance, children up-to-date on immunizations, children receiving medical and oral health screenings and follow-up care., children / families enrolled in WIC, and children receiving mental health services.	<u>Short Term</u> 1. Increased access to oral health among low-income children. <u>Long Term</u> 2. Increased access to primary health, including immunizations, among low-income children. 3. Increased access to mental health, based on needs identified in PIR data.	1. Children enter school healthy and ready to learn and, thus, experience greater success in school. 2. A comprehensive system of services is responsive to the mental health needs of young children.

Resources	Activities	Outputs	Short- & Long-term Outcomes	Impact
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
	Manager and HS grantees to continue building systems that increase access to oral health screenings, exams, and treatments for HS children and families. 5. SCO and NHSA will work together to track Family Development Matrix data from all HS grantees, enabling the reporting of statewide data and outcomes.			

Priority areas on the following pages were not selected as priorities for 2007, and therefore were not updated. They will be scrutinized and revised during 2007.

LMD Program Planning **Initiative Area: ECE Part II, State Pre-K, Child Care, & HS Partnerships**

1. Intentions & Issues	Collaboration and coordinated programming among HS, State Pre-K, and Child Care will lead to broader service provision for children and will contribute to full enrollments for early childhood programs. Existing gaps in service provision or maintenance of full enrollment in some communities that are served by both HS and State Pre-K programs will be decreased or eliminated through coordinated programming.
2. Community Needs & Assets	Assets • HS programs conduct community needs assessments every three years, so fairly current data is available regarding program eligibility of community populations. Needs • HS programs need to maintain full enrollment or program funding / numbers of enrollment slots can be reduced through decreased funding. (on the part of the Regional Office), • Needs assessments indicate that HS is serving 20percent of income eligible population in Nevada. However, these populations are generally located in the two urban centers of the state. Rural HS programs sometimes have difficulty maintaining full enrollment in areas where State Pre-K programs are co-located.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• Feds are directing HS to partner with State Pre-K programs, as well as Child Care. However, at this point, the Dept of Education has not been directed to partner with HS. • HS Re-authorization includes mandatory partnering between HS and State Pre-K. • HS has a lower income poverty guideline for enrollment qualifying than do State Pre-K programs. • If full-day kindergarten is implemented in Nevada, State Pre-K and HS program sites could be displaced.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• State Pre-K funding will continue and could possibly be increased. • HS funding in Nevada will remain constant. (No expansion for new enrollment slots and no loss of current enrollment slots if programs maintain full enrollment.) • Feds are going to require addressing barriers to collaboration between HS, State Departments of Education, and Child Care.

LMD Program Implementation (Timeframe: 2007) **Initiative Area: ECE Part II, State Pre-K and HS Collaboration**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO SCO Steering Committee SCO Partnership Committee SCO Work Group HSA and HS grantees State Nevada Dept of Education School District Superintendents State Pre-K program staff	1. Work group convenes to collect data determining need and to develop plan to coordinate HS, State Pre-K, and Child Care services. 2. Identify successful models for State Pre-K and HS program coordination. 3. HS and State Pre-K program staff produce annual professional development plans to include staff from both programs, as well as other ECE professionals in the community. 4. HS directors develop working relationship with State Pre-K program administrators and school district administration.	1. Four integrated training plans are developed by HS, State Pre-K, and Child Care representatives. 2. Centers are prepared for coordinated services. 3. Data report indicates numbers of children being served through coordinated programming, identifies areas where coordinated planning is most necessary, and aids future planning. 4. Coordination activities are reflected in the State ECCS plan.	Short 1. MOU's for integrated program and service delivery are developed between community HS and State Pre-K programs.	1. State Pre-K, Child Care, and HS programs participate in coordinated, inter-agency service delivery.

LMD Program Planning **Initiative Area: Literacy**

1. Intentions & Issues	Head Start is mandated with helping families to improve their literacy rates, which includes Second Language Acquisition for non-English speaking families. Data indicates that family literacy is critical for children's success in school.
2. Community Needs & Assets	Assets • The HS FDM can serve as an assessment tool for literacy needs. • HS Community Needs Assessments are updated every 3 years. • The 18-24 State Initiative can be used as a tool for literacy data. • NV Dept of Ed works with state-wide ABE/ESL programs to provide support for classes. • The Family Story Teller programs serve English, ESL, and tribal populations. • Libraries throughout the state provide local literacy programs. • Even Start Family Literacy programs are available in some communities within Nevada. Needs • Waiting lists for ESL classes are quite long in some areas of Nevada. • There is no comprehensive, statewide inventory of available literacy programs.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• Adults often hide their lack of literacy skills, so it is difficult to get accurate data regarding literacy levels. Reliability of existing literacy data is questionable. • ESL class attendance is sometimes sporadic, leaving their effectiveness in question. • Possibility exists that federal ABE/ESL program funding will be decreased. • The 18 – 24 Initiative director has shared a desire to work with the Head Start SCO and HS programs.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• The Family Development Matrix will continue to provide semi-annual data. • ABE/ESL funding will continue at some level. • The federal government will continue to emphasize improved literacy rates, so it will remain a high priority for the HS SCO.

LMD Program Implementation (Timeframe: 2006-2010) **Initiative Area: Literacy**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO HSA and HS grantees SCO Steering Committee SCO Partnership Committee SCO Work Group NDE: ABE & ESL KNPB - Ready to Learn Family Story Teller ABE/ESL Programs 18-24 Initiative State Library & Archives Literacy Coordinator Federal Even Start UNR Literacy Research	1. Develop a process to accurately assess literacy/ESL levels of need for all HS regions in the state. 2. Develop a process to annually determine available literacy & ESL programs for all regions of the state. 3. Work group (of all partners or as part of the ECCS) to develop a plan for addressing barriers that have prevented literacy program collaboration and participation at local and state levels. 4. Work group to assess needs and develop plan to address English Language Learner (ELL) curriculum.	1. Annual statewide/region reports of adult literacy and ESL rates. 2. Annual statewide/regional reports of available literacy/ESL services. 3. Written plan to address barriers to literacy services participation. 4. Written plan to address ELL curriculum.	1. Improved data of statewide literacy levels. 2. Literacy services for HS parents more accurately reflect their needs. 3. Adults are enrolled in appropriate ELL literacy and ESL programs.	1. Literacy and ESL rates of HS parents improve. 2. As a result of improved adult literacy and ESL rates, children's literacy and ESL rates increase so that children are successful in school. 3. Children's learning is enhanced through parent's success, thus children enter kindergarten better prepared for learning.

LMD Program Planning **Initiative Area: Infrastructure**

1. Intentions & Issues	The results of the 2005 NV HS SCO Self-Evaluation indicate a need for change in order to clarify/improve leadership and increase the level of active participation for partners so they feel more vested in the process. A strategic planning process has led to recommendations for changing the infrastructure of the SCO.
2. Community Needs & Assets	Assets • Members of the strategic planning process have received training in the Kellogg Foundation's Logic Model Development. • SCO Self-Evaluation points to specific areas of needed change. • Dr. David Drake continues to be a strong asset in assisting the SCO change process. • The participants of the Strategic Planning process are strongly supportive of the change plan.
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• The SCO has just moved from Welfare/Child Care into the DHHS Director's Office. This should lead to stronger lead agency support and may also bring about other changes, as yet unknown. • HS Re-Authorization is pending and there may be changes in the new legislation that affects SCO functions. • The Federal HS Bureau and RO will provide input of the plan.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• SCO funding (from the Feds) will continue. • The SCO and HSA will continue to work closely together. • Existing partnerships will be maintained and new partnerships will be developed.

LMD Program Implementation (Timeframe: 2006) **Initiative Area: Infrastructure**

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO SCO Steering Committee SCO Partnership Committee SCO Work Group HSA & HS Grantees Attorney General's Office State agencies, as relevant to annual initiative area focus.	1. Establish a small work group to re-write and obtain approval for SCO By-laws, incorporating new infrastructure. 2. Establish a workgroup to develop a Committee Member Manual and Orientation process. 3. Evaluate Partnership Committee annually for necessary changes. 4. Implement new 3-tier committee structure and notify all participants of membership. 5. Review annual activity plan at quarterly meetings to assess progress and identify barriers. 6. Develop evaluation survey for meetings.	1. New By-Laws in place. 2. All partners have a Committee Member Manual. 3. New partners complete Orientation process. 4. New committee structures in place. 5. New leadership structure in place. 6. Annual activity plans are realistic and achievable. 7. Logic model development/strategic planning process in place for annual use. 8. Report tracks action plan progress and completion. 9. Evaluation surveys are completed for each quarterly meeting.	1. Improved collaboration and increased active involvement of SCO partners. 2. Better tracking of activity plan progress through quarterly reviews. 3. Improved Self-Evaluation assessment. 4. Increased completion percent of action plans. 5. HS SCO partners are satisfied with new infrastructure changes, including new format for quarterly meetings.	1. Improved HS SCO functioning, including planning and implementation of action plans.

LMD Program Planning **Initiative Area: Information Dissemination & Grant Administration**

1. Intentions & Issues	There are many activities/working groups functioning within the State. In a state like Nevada, where there are only eight grantees, it is difficult for HS to be present and involved in all of these activities. The HS SCO is required to participate in some of these activities and can serve as a communication liaison to HS grantees.
2. Community Needs & Assets	Assets • The SCO has compiled comprehensive traditional and electronic mailing lists. Needs • There is a need to synthesize & distribute the mass amount of information generated throughout the state. • The SCO has mechanisms (Children's Link and HS Fact sheet) for distributing information throughout the state. However, the effectiveness of these publications is unclear, so baseline data is needed to determine the best avenue for information dissemination. • The SCO needs to meet requirements of the Feds and State lead agency in participating in various initiatives. (Pre-K Standards development, ECCS, Homelessness, etc.)
3. Desired Results (Outputs, Outcomes, and Impacts)	See: Program Implementation Matrix
4. Influential Factors	• Federal requirements of SCO to focus on special initiatives as they occur. • Partnership with Nev Association Education of Young Children (Nev AEYC) and Washoe County School District (WCSD), which provides funds for printing the quarterly newsletter, the *Children's Link.* • Location of HS SCO within State system. • HS grantees' abilities to participate in various activities and/or their need for information. • It is unknown if funding will continue to be available for printing the newsletter.
5. Strategies	See: Program Implementation Matrix
6. Assumptions	• The Fact sheet will continue to be produced annually through SCO funding. • Information dissemination will continue to be part of the SCO scope of work.

LMD Program Implementation (Timeframe: On-going) Initiative Area: Information Dissemination & General Grant Administration

Resources	**Activities**	**Outputs**	**Short- & Long-term Outcomes**	**Impact**
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset, we will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence of service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished, these activities will lead to the following changes in 7-10 years:*
SCO SCO Steering Committee SCO Partnership Committee SCO Work Group HSA and HS grantees Nev AEYC State agencies Non-profits, as applicable Media/Marketing people	1. Work with other EC agencies to increase & update mailing distribution lists. 2. Produce HS Fact sheet for statewide distrib. 3. Develop/conduct survey to evaluate effectiveness of newsletter and determine best means of info dissemination. Consider SCO's time, audience needs, level of use by and usefulness for readers, etc. 4. Participate in collab processes of various agencies, based on direction from Feds, State lead agency, or need. 5. Administer all grant mandates and meet reporting requirements. 6. Work group determines best avenue for developing SCO marketing tool.	1. Updated and more comprehensive distribution lists. 2. Increased circulation of information being shared via best means determined (newsletter, Fact sheet, electronic, etc.). 3. HS Fact sheet 4. Newsletter evaluation results and suggestions for the best avenues of information dissemination have been analyzed and adopted. 5. Quarterly and annual reports for feds, state, and partners. 6. Annual strategic plan. 7. Self-evaluation report.	1. Early childhood professionals throughout the state are well-informed of current issues, initiatives, and events relating to ECE. 2. The most effective means of information dissemination has been identified and implemented. 3. All grant mandates are met, resulting in effective collaboration throughout the state.	1. Nevada early childhood professionals have developed a well-integrated, comprehensive system of information sharing that results in improved quality of care for children due to early childhood professionals making the best use of information received. 2. Statewide collaboration and formalized partnerships improve comprehensive services for all low-income children in Nevada. 3. Nevada HS SCO has developed an integrated and inclusive process for grant planning and administration.

004-(1)

Grade - 4 | Reading | CRT Results - Detailed View | View

For more information about assessment in Nevada, click here.

CRT - Grade 4
Annual Measurable Objective (AMO): 39.6%

	Reading						
	Number Enrolled	Not Tested	% Above AMO	1	2	3	4
State Graph 1 Graph 2	32,842	0.40%	18.20%	13.00%	29.20%	41.50%	16.30%
Male	16,844	0.40%	13.10%	16.10%	31.10%	38.30%	14.50%
Female	15,968	0.30%	23.60%	9.70%	27.10%	44.90%	18.20%
American Indian/Alaskan Native	526	0.40%	13.10%	13.70%	33.60%	42.40%	10.30%
Asian/Pacific Islander	2,646	0.60%	30.20%	6.70%	23.50%	48.40%	21.40%
Hispanic	12,201	0.30%	4.60%	18.60%	37.20%	36.60%	7.60%
Black/African American	3,606	0.50%	4.90%	19.70%	35.80%	34.60%	9.90%
White/Caucasian	13,769	0.30%	31.70%	7.40%	21.20%	46.40%	24.90%
IEP	3,603	0.70%	-15.00%	41.40%	34.00%	19.30%	5.20%
LEP	6,681	0.50%	-14.70%	27.70%	47.40%	23.60%	1.30%
FRL	14,382	0.40%	4.30%	19.20%	36.90%	36.20%	7.70%
Migrant	12	0.00%	-6.30%	16.70%	50.00%	25.00%	8.30%

Data as of: 06-07 Testing Period

District totals include district-sponsored charter school data, but not state-sponsored charter school data. District totals in reports released prior to 2006-2007 do not include charter school data.

Achievement (Standard)
1. Emergent/Developing - Student occasionally/does not apply skills/strategies and requires extensive remediation.
2. Approaches Standard - Student inconsistently/incompletely applies skills/strategies and requires targeted remediation.

3. Meets Standard - Student consistently applies skills/strategies without need for remediation.
4. Exceeds Standard - Student comprehensively/consistently applies and generalizes skills/strategies in a variety of situations.

IEP = Students with disabilities.
LEP = Students with Limited English Proficiency.
FRL = Students qualifying for Free/Reduced Lunch.

'-' indicates data not presented for groups fewer than 10.
'N/A' indicates that this population was not present.
'*' indicates that these data were not available.

APPENDIX E: Data Source Information

Nevada Annual Reports of Accountability

Friday 23, May 2008

Report Card - 2006-2007
State of Nevada
Demographic Profile
Fiscal Information
Technology
Students
Personnel
Assessment
Adequate Yearly Progress
National Assessment for Educational Progress
Download

State of Nevada - National Assessment for Educational Progress

For additional information on the National Assessment of Educational Progress, please visit the NAEP web site at http://www.nces.ed.gov/nationsreportcard/state

Subject	Grade	Year	Scale Score: State Avg.	Scale Score: [Nat. Avg.]*	Achievement Level Percent at or Above: Basic[1]	Proficient	Advanc
Mathematics (scale: 0-500)	4	1996[n]	218	[222]	57	14	1
		2000	220	[224]	60	16	1
		2003	228	[234]	69	23	1
		2005	230	[237]	72	26	3
	8	2000	265	[272]	55	18	2
		2003	268	[276]	59	20	3
		2005	270	[278]	60	21	3
Reading (scale: 0-500)	4	1998	206	[213]	51	20	4
		2002	209	[217]	54	21	3
		2003	207	[216]	52	20	3
		2005	207	[217]	52	21	4
	8	1998	258	[261]	70	23	1
		2002	251	[263]	62	19	1
		2003	252	[261]	63	21	1
		2005	253	[260]	63	22	1
Science (scale: 0-300)	4	2000[n]	142	[148]	58	19	1
		2005	140	[149]	55	17	1
	8	2000[n]	141	[148]	52	22	2
		2005	138	[147]	48	19	1
Writing (scale: 0-300)	4	2002	145	[153]	82	18	1
	8	1998	140	[148]	77	17	0
		2002	137	[152]	75	16	1

* Includes public schools only

[n] Accommodations were not permitted for this assessment

[1] Students who scored below the Basic achievement level are not included in this table.

PBRM 1

NCCP National Center for Children in Poverty
Columbia University
MAILMAN SCHOOL OF PUBLIC HEALTH

REGION IX EARLY CHILDHOOD PROFILE

State policies that promote health, education, and strong families can help the early development and school readiness of America's youngest citizens. This regional profile summarizes the policy choices of the 6 states in Region IX, alongside other contextual data related to the well-being of young children. These states include: California, Nevada, Arizona, and Hawaii.

This page presents demographic information on children younger than age 6, and subsequent pages profile the policy context related to their: (1) health and nutrition, (2) early care and education, and (3) parenting and economic supports. State specific profiles are also available.

Complete source citations and endnotes are included with this profile. For easy reference, the year of the data appears in brackets. To show the range of variation among states, some graphs identify the states with the highest and lowest percentages alongside the national average.

In addition to the state and regional profiles, the project includes:

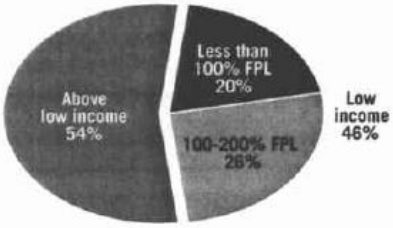
- A national profile
- Data tables that allow for comparisons across states on each policy choice
- A national report summarizing the research base for policies that promote early childhood development and key findings from the state profiles.

These and other related documents are available on the NCCP website at: <www.nccp.org/projects/improvingtheodds.html>.

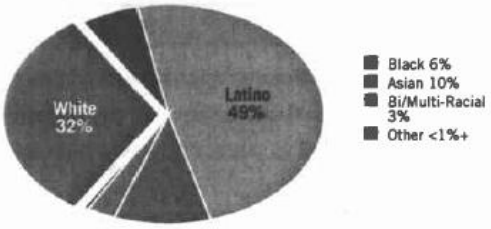
Updated: February 20, 2008

Young children (under age 6)[1]: 3,920,613
Infants and toddlers (under age 3)[1]: 2,000,993

Young children by income, 2006[1]

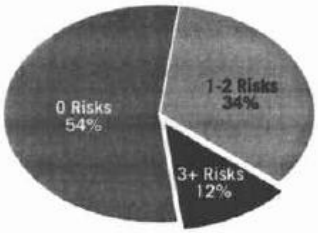


Young children by race/ethnicity, 2006[1]



+"Other" represents all racial/ethnic groups with very small sample sizes

Exposure to multiple risk factors* among young children, 2006[2]



* Risk factors include any combination of the following: single parent, living in poverty, parents do not speak English well, parents have less than a high school education, and parents have no paid employment.

215 WEST 125TH STREET, 3RD FLOOR ■ NEW YORK, NY 10027 ■ TEL 646-284-9600 ■ FAX 646-284-9623 ■ www.nccp.org

PBR11-2

U.S. Census Bureau

CPS Data Collected in Year: 2007
Persons - All

(Numbers in Whole Numbers)

NOTE: The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Some CPS questions, such as income, ask about the previous year. Others, such as age, refer to the time of the survey. The column labels indicate any subject with a reference year which differs from the survey year.

Data are for the Subset: State: NV & Age: 00 to 06 years

Totals	**Totals**	252,066
	Race White	
	White alone or in combination	206,984
	Other	45,082
Origin		
Non Hispanic	**Totals**	160,503
	Race White	
	White alone or in combination	118,320
	Other	42,183
Hispanic	**Totals**	91,563
	Race White	
	White alone or in combination	88,664
	Other	2,899

Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2007

SAS Output

PBRM - 3

U.S. Census Bureau

CPS Data Collected in Year: 2007

Persons in Poverty Universe

(Numbers in Whole Numbers)

NOTE: The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Some CPS questions, such as income, ask about the previous year. Others, such as age, refer to the time of the survey. The column labels indicate any subject with a reference year which differs from the survey year.

State: NV	Totals	Income-to-Poverty Ratio in 2006			
		Below 50%	50% to below 100%	100% to below 200%	200% and above
Totals	251,508	20,373	24,106	62,491	144,538
Age					
00 to 06	251,508	20,373	24,106	62,491	144,538

Source: U.S. Census Bureau

Current Population Survey, Annual Social and Economic Supplement, 2007

PBRM-4

Please be patient. Due to the size of database, it will take a little while to process a query.
In most cases, the output from a query needs 1 to 5 minutes.

Query: NIHDS, Low Birth Weight Module (Nevada, 1990 - 2004)

'X' may appear in the requested table. This is to protect the prviacy of individuals and the integrity of the data due to a small number in your result. Please try your query again with a broader scope (i.e. more years) to get a result for this characterisitic.

- ***((State of Residence = Nevada))***
- ***and ((State of Residence = Nevada))***
- ***and ((Year of Birth=2004))***

Use the drill-down variable tool to amend the current query County of Residence

% of Low Birth Weight (less than 2,500g)

Year of Birth	Detail Information			
	Number of Low Birth Weight Live Birth (less than 2,500g)	Number of Total Live Birth	% of Low Birth Weight	95% Confidence Interval
All	2,799	35,146	7.96	7.68 - 8.25
2004	2,799	35,146	7.96	7.68 - 8.25

'number0+3.8416' is not recognized as an internal or external command, operable program or batch file.

Next Query | Data Source | Interpretation | Help

Contact me at wyang@nvhd.state.nv.us

PBRM - 5

Please be patient. Due to the size of database, it will take a little while to process a query.
In most cases, the output from a query needs 1 to 5 minutes.

Query: NIHDS, Teen Pregnancy Module (Nevada, 1990 - 2004)

'X' may appear in the requested table. This is to protect the prviacy of individuals and the integrity of the data due to a small number in your result. Please try your query again with a broader scope (i.e. more years) to get a result for this characterisitic.

- ***((State of Residence = Nevada))***
- ***and ((Year of Birth=2004))***

Use the drill-down variable tool to amend the current query County of Residence

Teen Birth Rate per 1,000 Teen Females (Ages 15 to 17)

Year of Birth	Detail Information			
	Number of Live Births to Females of Ages 15-17 Years	Number of Females of Ages 15-17 Years	Teen Birth Rate per 1,000 Teen Females (Ages 15-17)	95% Confidence Interval
All	1,266	48,323	26.20	24.77 - 27.62
2004	1,266	48,323	26.20	24.77 - 27.62

't1' is not recognized as an internal or external command, operable program or batch file.

Next Query | Data Source | Interpretation | Help

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H&M -01

U.S. Census Bureau

CPS Data Collected in Year: 2007

Persons - All

(Numbers in Whole Numbers)

NOTE: The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Some CPS questions, such as income, ask about the previous year. Others, such as age, refer to the time of the survey. The column labels indicate any subject with a reference year which differs from the survey year.

NOTE: Health insurance data for 2005 and 2006 were updated on April 10, 2007. Refer to the Revised CPS ASEC Health Insurance Data page for more information. The health insurance data from 2003 and 2004 were constructed for consistency with the revision to the 2005 and 2006 data. The health insurance coverage tables created should match the results from our new historical series tables HIA-1 through HIA-8.

State: NV	Totals	Health Insurance Coverage in 2006	
		Insured	Uninsured
Totals	218,063	168,460	49,603
Age			
00 to 05	218,063	168,460	49,603

Source: U.S. Census Bureau

Current Population Survey, Annual Social and Economic Supplement, 2007

DataQueryPrint

H & M - 2

Print Close

Selected Criteria:

- Survey Sections
- Nevada
- 2003
- Medical Home (Survey Section 5)
- Children/youth (ages 0-17) with and without medical home
- Age - 3 groups

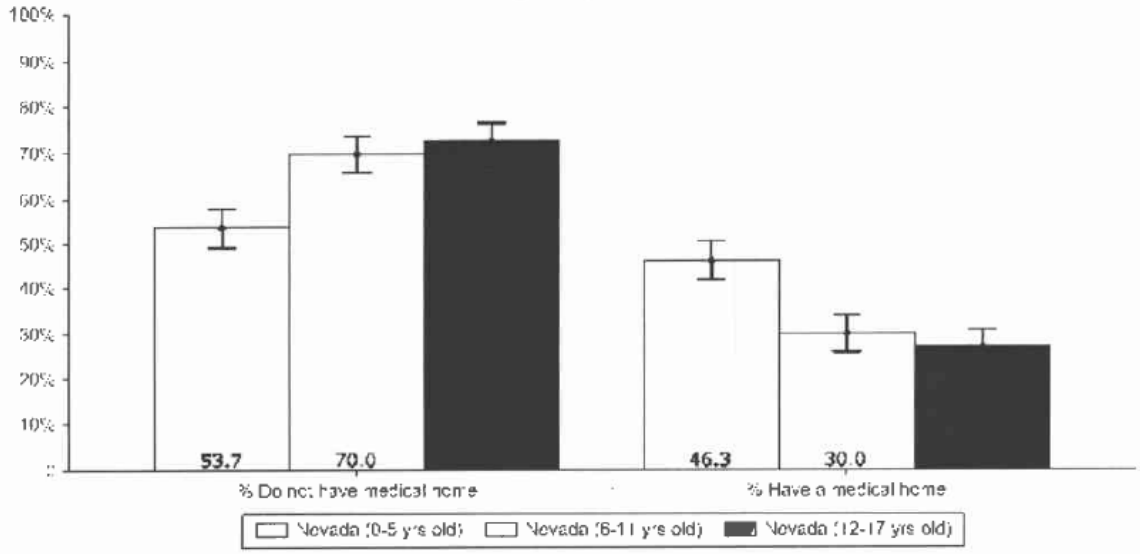
Question: Indicator 4.8: How many children/youth (ages 0-17) receive health care that meets the American Academy of Pediatrics (AAP) definition of medical home? (derived)

		% Do not have medical home	% Have a medical home	Total %
0-5 yrs old	%	**53.7**	**46.3**	**100.0**
	C.I.	(49.4 - 57.9)	(42.1 - 50.6)	
	n	376	328	
	Est.	103,319	89,257	
6-11 yrs old	%	**70.0**	**30.0**	**100.0**
	C.I.	(66.0 - 74.0)	(26.0 - 34.0)	
	n	448	194	
	Est.	135,776	58,098	
12-17 yrs old	%	**73.0**	**27.0**	**100.0**
	C.I.	(69.1 - 76.8)	(23.2 - 30.9)	
	n	501	191	
	Est.	135,566	50,164	

For a detailed explanation of the data MOVE your cursor over the text in the table or the bold text below
C.I. = 95% Confidence Interval. Percentages are weighted to population characteristics.
n = Cell size. Use caution in interpreting Cell sizes less than 50.

Children/youth (ages 0-17) with and without medical home
Nevada

Age - 3 groups



Citation format: Child and Adolescent Health Measurement Initiative. *2003 National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Retrieved [mm/dd/yy] from www.nschdata.org

H&H 4

Estimated Vaccination Coverage* with 4:3:1:3:3† Among Children 19-35 Months of Age by Race/Ethnicity‡ and by State and Local Area -- US, National Immunization Survey, Q3/2006-Q2/2007§

	Total	White only, non-Hispanic	Black only, non-Hispanic	Hispanic	American Indian or Alaska Native only, non-Hispanic	Asian only, non-Hispanic	Native Hawaiian or other Pacific Islander only, non-Hispanic	Multiple Race, non-Hispanic
Nevada	65.4±6.6	65.2±9.7	NA	NA	NA	NA	NA	NA
New Hampshire	91.5±3.7	92.3±3.8	NA	NA	NA	NA	NA	NA
New Jersey	80.3±5.7	81.4±7.4	NA	NA	NA	95.5±6.2	NA	NA
New Mexico	81.0±5.4	72.1±9.1	NA	87.2±5.7	NA	NA	NA	NA
New York	85.8±3.0	83.0±4.5	85.3±7.8	89.8±5.2	NA	NA	NA	NA
NY-City of New York	81.9±4.6	74.7±8.9	NA	84.9±7.4	NA	94.6±7.6	NA	NA
NY-Rest of State	89.4±3.8	86.3±5.0	NA	NA	NA	NA	NA	NA
North Carolina	82.4±5.6	83.9±7.3	NA	NA	NA	NA	NA	NA
North Dakota	80.5±5.5	82.4±5.5	NA	NA	NA	NA	NA	NA
Ohio	80.3±5.6	84.5±4.8	NA	NA	NA	NA	NA	NA
Oklahoma	79.5±5.2	81.0±6.5	NA	NA	NA	NA	NA	NA
Oregon	74.4±6.5	73.2±8.2	NA	NA	NA	NA	NA	NA
Pennsylvania	81.6±3.8	81.9±4.8	83.7±7.8	NA	NA	NA	NA	NA
PA-Philadelphia County	80.8±6.1	90.1±7.2	79.2±10.0	NA	NA	NA	NA	NA
PA-Rest of State	81.7±4.4	81.4±5.1	NA	NA	NA	NA	NA	NA
Rhode Island	84.4±5.1	85.2±6.2	NA	NA	NA	NA	NA	NA
South Carolina	81.6±5.0	80.6±6.2	88.9±9.8	NA	NA	NA	NA	NA
South Dakota	84.2±5.1	89.0±4.6	NA	NA	NA	NA	NA	NA
Tennessee	80.8±5.4	84.7±5.6	NA	NA	NA	NA	NA	NA
Texas	76.4±3.8	75.1±7.8	NA	79.7±4.3	NA	NA	NA	NA
TX-Bexar County	78.3±5.9	89.0±7.9	NA	77.6±7.3	NA	NA	NA	NA
TX-City of Houston	70.6±6.8	NA	NA	76.7±7.4	NA	NA	NA	NA
TX-Dallas County	74.9±6.2	NA	NA	78.1±8.6	NA	NA	NA	NA
TX-El Paso County	74.1±5.7	NA	NA	75.1±6.0	NA	NA	NA	NA
TX-Rest of State	77.6±5.6	74.7±9.4	NA	81.6±6.8	NA	NA	NA	NA
Utah	79.6±5.7	78.9±6.6	NA	NA	NA	NA	NA	NA
Vermont	87.1±5.1	85.6±5.7	NA	NA	NA	NA	NA	NA
Virginia	80.2±5.0	82.0±5.9	NA	NA	NA	NA	NA	NA
Washington	78.3±5.0	76.2±6.4	NA	NA	NA	NA	NA	94.8±5.0
West Virginia	81.2±5.0	80.7±5.4	NA	NA	NA	NA	NA	NA
Wisconsin	84.2±4.9	86.7±5.8	NA	NA	NA	NA	NA	NA
Wyoming	75.8±5.7	76.4±6.6	NA	NA	NA	NA	NA	NA

* Estimate=NA (Not Available) if the unweighted sample size for the numerator was <30 or (CI half width)/Estimate > 0.5 or (CI half width) >10. Estimates presented as point estimate (%) ± 95% Confidence Interval.

† 4 or more doses of DTaP, 3 or more doses of poliovirus, 1 or more doses of MMR, 3 or more doses of Hib, and 3 or more doses of HepB.

‡ Self-reported by respondent. Individual racial groups do not include Hispanic children. Children of Hispanic ethnicity may be of any race.

§ Children in the Q3/2006-Q2/2007 National Immunization Survey were born between July 2003 and December 2005.

tab29_43133_race_iap.xls

Estimated Vaccination Coverage* with 4:3:1:3:3† Among Children 19-35 Months of Age by Race/Ethnicity‡ and by State and Local Area -- US, National Immunization Survey, Q3/2006-Q2/2007§

	Total	White only, non-Hispanic	Black only, non-Hispanic	Hispanic	American Indian or Alaska Native only, non-Hispanic	Asian only, non-Hispanic	Native Hawaiian or other Pacific Islander only, non-Hispanic	Multiple Race, non-Hispanic
US National	80.4±0.9	81.7±1.1	76.0±2.9	80.3±1.8	81.5±8.0	79.7±4.5	87.5±10.0	78.9±4.7
Alabama	81.9±5.8	83.1±7.4	NA	NA	NA	NA	NA	NA
Alaska	75.9±5.9	68.4±9.0	NA	NA	91.1±7.3	NA	NA	NA
Arizona	76.2±5.4	79.6±6.2	NA	73.1±8.9	NA	NA	NA	NA
Arkansas	76.3±6.3	76.6±6.9	NA	NA	NA	NA	NA	NA
California	78.6±3.2	78.6±6.8	NA	78.7±4.2	NA	NA	NA	NA
CA-Alameda County	81.4±6.5	85.9±8.9	NA	84.4±9.6	NA	NA	NA	NA
CA-Los Angeles County	81.1±4.4	85.2±8.0	NA	77.9±5.9	NA	NA	NA	NA
CA-San Bernardino County	73.0±7.4	NA	NA	71.5±9.2	NA	NA	NA	NA
CA-Rest of State	77.8±4.7	77.3±8.6	NA	79.8±6.4	NA	NA	NA	NA
Colorado	79.2±7.2	81.3±8.7	NA	NA	NA	NA	NA	NA
Connecticut	87.5±4.7	91.0±4.3	NA	NA	NA	NA	NA	NA
Delaware	83.7±5.5	85.8±7.4	NA	NA	NA	NA	NA	NA
District of Columbia	82.7±5.3	90.4±6.2	78.5±8.6	89.1±8.8	NA	NA	NA	NA
Florida	83.7±3.9	83.1±6.1	86.3±7.8	80.4±7.5	NA	NA	NA	NA
FL-Miami-Dade County	82.4±5.7	NA	NA	84.9±6.9	NA	NA	NA	NA
FL-Rest of State	83.9±4.5	82.8±6.3	88.5±8.7	NA	NA	NA	NA	NA
Georgia	83.5±5.0	82.1±6.8	NA	NA	NA	NA	NA	NA
Hawaii	83.7±6.5	NA	NA	NA	NA	NA	90.0±9.3	NA
Idaho	78.7±5.9	81.4±6.5	NA	NA	NA	NA	NA	NA
Illinois	76.6±5.4	79.3±7.1	NA	82.5±7.8	NA	NA	NA	NA
IL-City of Chicago	75.8±6.5	84.8±7.2	NA	77.3±8.8	NA	NA	NA	NA
IL-Rest of State	76.9±6.9	78.7±7.8	NA	NA	NA	NA	NA	NA
Indiana	79.7±4.6	81.1±5.5	NA	88.6±6.9	NA	NA	NA	NA
IN-Marion County	71.7±6.3	80.0±7.6	NA	NA	NA	NA	NA	NA
IN-Rest of State	81.3±5.4	81.3±6.1	NA	NA	NA	NA	NA	NA
Iowa	83.1±5.4	86.2±5.5	NA	NA	NA	NA	NA	NA
Kansas	79.5±4.9	79.0±6.0	NA	84.3±9.8	NA	NA	NA	NA
Kentucky	80.3±6.2	82.8±6.9	NA	NA	NA	NA	NA	NA
Louisiana	73.8±7.0	77.9±6.8	NA	NA	NA	NA	NA	NA
Maine	81.8±5.9	83.1±6.3	NA	NA	NA	NA	NA	NA
Maryland	86.2±4.0	88.2±5.5	83.1±8.4	NA	NA	NA	NA	NA
Massachusetts	88.3±4.7	90.5±4.7	NA	NA	NA	NA	NA	NA
Michigan	81.8±4.8	85.3±5.4	NA	92.5±8.1	NA	NA	NA	NA
Minnesota	85.5±4.7	85.2±5.2	NA	NA	NA	NA	NA	NA
Mississippi	74.0±6.8	74.2±9.4	NA	NA	NA	NA	NA	NA
Missouri	82.1±5.7	84.1±6.1	NA	NA	NA	NA	NA	NA
Montana	74.9±5.7	73.9±6.7	NA	NA	NA	NA	NA	NA
Nebraska	81.9±6.5	85.9±5.9	NA	NA	NA	NA	NA	NA

tab29_43133_race_iap.xls

H & M 5

Table 2: Questionnaire Summary

	Number	Percent *	95% CI
Q1. How long since child's last dental visit	1749		
Within the past year	1313	75%	+/- 6.22
More than 1 year, no more than 3 years ago	123	7%	+/- 1.47
More than 3 years ago	29	2%	+/- 0.66
Never been to dentist	151	8%	+/- 3.34
No response	133	8%	+/- 6.27
Q2. Main reason for last dental visit	1749		
Routine check-up or cleaning	1082	62%	+/- 6.07
Called in by dentist for check-up or cleaning	118	7%	+/- 2.65
Something was wrong or hurting	66	4%	+/- 1.13
Follow-up visit from prior visit	102	6%	+/- 1.18
Other	92	5%	+/- 1.07
Never been to dentist	147	8%	+/- 3.21
No answer	142	9%	+/- 6.38
Q3. Is there medical insurance for child	1730		
Yes	1123	64%	+/- 5.28
No	495	29%	+/- 3.19
No response	112	7%	+/- 5.99
Q4. Is there dental insurance for child	1724		
Yes	1029	60%	+/- 5.47
No	544	31%	+/- 3.20
No response	151	9%	+/- 6.21
Q5. Difficulty accessing dental care	1727		
Yes	256	15%	+/- 2.38
No	1258	72%	+/- 6.17
Did not answer	213	13%	+/- 6.47
Q6. Reason for difficulty **	256		
No insurance	134	52%	
Could not afford	112	45%	
Difficulty in getting appointment	22	8%	
Didn't know where to go	16	7%	
Dentist did not accept Medicaid	16	7%	
Not serious enough problem	13	5%	
No Dentist available	10	5%	
No way to get there	12	4%	
Wait is too long in clinic/office	7	4%	
Dentist hours are not convient	5	2%	

H & H 6 and 7

Table 1. State-specific prevalence of selected nutrition indicators for children aged <5 years, 2006 Pediatric Nutrition Surveillance System

Contributor	LBW*	HBW†	Ever Breastfed	Breastfed 6 Months	Anemia‡	Short Stature§	Overweight‖
Alabama	12.4	4.9	33.9	2.0	19.0	6.8	13.7
Arizona	8.4	6.9	61.1	25.1	16.5	7.8	13.5
Arkansas	9.7	5.9	45.2	9.2	15.7	8.2	13.2
California	6.4	7.7	NA	NA	14.0	5.1	17.0
Cheyenne River Sioux (SD)	8.3	7.7	NA	NA	16.1	1.5	18.4
Colorado	10.1	4.6	74.2	28.9	12.1	8.1	9.6
Connecticut	9.5	6.7	57.8	24.6	9.4	3.9	16.2
District of Columbia	12.0	4.9	NA	NA	28.8	9.1	15.4
Florida	9.7	5.9	66.3	24.4	16.7	4.8	13.9
Georgia	10.4	5.4	52.4	18.4	13.2	7.3	14.5
Idaho	7.5	7.5	78.9	27.8	12.7	7.0	12.4
Illinois	9.7	6.2	61.2	18.2	10.9	7.4	14.4
Indiana	9.5	6.3	60.0	19.2	15.9	6.7	14.0
Inter Tribal Council (AZ)	7.7	9.2	60.2	31.7	10.4	7.0	24.1
Iowa	8.8	7.7	NA	NA	9.4	5.8	14.6
Kansas	8.3	6.7	66.0	22.2	9.4	6.2	13.8
Kentucky	10.2	6.1	NA	NA	12.3	7.0	17.4
Maryland	11.2	6.0	55.5	39.6	22.3	6.6	14.8
Massachusetts	9.0	7.5	70.1	26.2	12.4	4.8	16.7
Michigan	9.8	7.3	51.2	15.8	12.9	6.8	13.3
Minnesota	7.4	9.1	71.0	32.6	11.6	5.1	13.1
Missouri	9.1	6.6	51.6	21.9	17.5	7.1	13.6
Montana	8.1	7.6	74.5	31.5	9.1	5.2	12.1
Navajo Nation (AZ)	7.2	6.5	75.4	30.8	8.1	5.5	16.3
Nebraska	8.6	6.7	67.8	24.4	16.4	5.7	13.1
Nevada	8.3	6.5	54.2	23.4	10.7	8.3	14.0
New Hampshire	8.0	9.0	64.6	22.8	13.8	6.7	15.9
New Jersey	9.3	6.2	58.9	33.7	18.9	6.1	18.1
New Mexico	10.0	4.6	71.5	23.8	10.0	7.7	11.5
New York	8.9	6.7	69.0	39.3	11.0	4.1	15.3
North Carolina	9.7	6.7	57.1	19.6	12.2	5.7	15.4
Ohio	11.1	5.7	44.4	16.6	13.6	6.6	11.7
Oregon	6.6	9.8	90.4	44.5	14.9	4.9	14.3
Pennsylvania	10.6	6.1	42.6	20.8	16.6	6.0	11.1
Puerto Rico	NA	NA	54.5	13.9	5.9	12.0	19.2
Rhode Island	8.8	7.6	54.3	17.3	16.4	6.6	16.5
Rosebud Sioux (SD)	8.3	6.6	60.7	NA	19.1	1.8	21.7
South Carolina	12.4	5.1	NA	NA	16.0	13.6	13.7
South Dakota	8.4	7.9	NA	NA	7.9	6.6	14.3
Standing Rock Sioux (ND)	3.2	8.4	NA	NA	13.7	1.5	24.8
Tennessee	10.9	5.4	40.7	15.6	7.5	5.9	13.1
Texas	9.0	6.0	67.6	37.8	18.2	7.2	15.6
Vermont	8.5	10.8	69.9	31.8	6.1	5.3	12.9
Virginia	9.9	6.3	58.3	23.1	14.8	6.7	17.0
Washington	7.4	9.6	83.1	38.8	11.0	5.3	14.2
West Virginia	10.8	5.5	42.1	11.8	5.6	5.4	12.7
Wisconsin	8.6	7.6	62.6	26.0	10.4	5.7	13.0
National PedNSS	**9.2**	**6.6**	**60.1**	**25.2**	**14.0**	**6.4**	**14.8**

* Low birthweight: <2,500 grams.
† High birthweight: >4,000 grams.
‡ Children aged 6 months to 2 years: hemoglobin (Hb) <11.0 g/dL or hematocrit (Hct) <32.9%. Children aged 2–5 years: Hb <11.1 g/dL or Hct <33.0%. Adjusted for altitude.
§ 2000 CDC growth chart percentiles: <5th percentile length-for-age for children younger than aged 2 years or <5th percentile height-for-age for children aged 2 years or older.
‖ 2000 CDC growth chart percentile: ≥95th percentile BMI-for-age for children aged 2 years or older.

H & M 8

Please be patient. Due to the size of database, it will take a little while to process a query.
In most cases, the output from a query needs 1 to 5 minutes.

Query: NIHDS, Hospital Discharge (Nevada, 1991 - 2005) - Last Updated on September 27, 2006

'X' may appear in the requested table. This is to protect the prviacy of individuals and the integrity of the data due to a small number in your result. Please try your query again with a broader scope (i.e. more years) to get a result for this characterisitic.

- ***((49300<=(ICD9 Code(s) Selected)<=49390))***
- ***and ((Year of Discharge=2004))***

Use the drill-down variable tool to amend the current query Year and Quarter

Number of Discharges

Age Group	General Diagnosis Groups	
	All	Diseases of the Respiratory System (460-519)
Total	1147	1147
Under 1 year	18	18 / 150
1 - 4 years	132	132 /
5 - 9 years	68	68
10 - 14 years	39	39
15 - 17 years	9	9
18 - 19 years	5	5
20 - 24 years	11	11
25 - 34 years	35	35
35 - 44 years	113	113
45 - 54 years	215	215
55 - 64 years	209	209
65 - 74 years	154	154
75+ years	139	139

$\frac{150}{179,563} \times 100$

'llowing' is not recognized as an internal or external command, operable program or batch file.

Next Query | Data Source | Interpretation | Help

Contact me at wyang@nvhd.state.nv.us

Query: NIHDS, Population Module (Nevada, 1990 - 2005)

'X' may appear in the requested table. This is to protect the prviacy of individuals and the integrity of the data due to a small number in your result. Please try your query again with a broader scope (i.e. more years) to get a result for this characterisitic.

- ***((Year of Population Count=2005))***

Use the drill-down variable tool to amend the current query Year of Population Count

Number of People

Race	Age Group									
	ALL	Less than 1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74
All	2,509,637	37,555	142,008	346,521	361,160	367,279	372,074	342,072	260,389	164,587
White	1,558,232	17,789	65,664	175,527	191,568	196,866	229,928	243,401	204,093	133,624
Black	172,949	2,972	11,398	29,274	29,372	24,148	25,480	22,523	13,872	8,707
Native American	33,542	464	1,813	4,934	5,623	5,014	5,196	4,630	3,245	1,685
Asian	159,431	2,328	10,190	20,706	22,006	26,224	25,886	23,043	15,646	8,978
Hispanic	585,483	14,002	52,944	116,080	112,591	115,027	85,584	48,475	23,533	11,592

(to be continued.)

Number of People

Race	Age Group	
	75-84	85+
All	92,230	23,761
White	78,630	21,142
Black	4,238	964
Native American	715	223
Asian	3,883	541
Hispanic	4,764	892

37,555
142,008
179,563

'oss_bld' is not recognized as an internal or external command, operable program or batch file.

Next Query

Contact me at wyang@nvhd.state.nv.us

http://health.nv.gov/cgi-bin/hi_iq_func.exe 5/23/2008

SNM - 1

Proposed Indicator Set for Early Childhood Comprehensive Systems (Draft 1-8-09)
Indicator / Performance Measure

LEGEND: BFHS=Data from Profile, BFHS?= Data might be in any of CSHN databases, A= Angel is exploring extracting from a NTL Database, ?= Data might be extracted from existing local Databases, X= No clue

SNM	1	Children birth to 3 years who receive Part C Early Intervention Services.
SNM	2	Children birth to age three with substantiated cases of abuse and neglect referred to Part C Early Intervention (based on CAPTA).

Fy 07
2,137
~~Duplicate~~
3rd Qtr Fy 08
~~Fy 07~~ 2,432
~~le to Capta~~
~~Referrals~~

FSPM **Family Support and Parenting Measures**

SNH 2

FY07 CAPTA STATISTICS

Early Intervention Programs received a total of 3,785 unduplicated referrals in FY07, and of those 616 were CAPTA referrals. The following are answers to questions that BEIS received from a member of the SPAC.

1. The number of CAPTA kids referred

- 616 CAPTA referrals, this is 16.3% of all new referrals received. ✓

2. The number of evaluations completed

- 118 of the CAPTA referrals failed the screening and were referred to Part C for evaluation; this is 19.2% of all CAPTA referrals.
  - 109 evaluations were completed for Part C; this is 17.7% of all CAPTA referrals.
  - There were 9 children in the Part C referral process on the last day of the fiscal year waiting for eligibility determination.

3. The number of kids who meet eligibility under IDEA

- 66 children were made eligible under Part C; this is 10.7% of all CAPTA referrals.
- 43 children were found not eligible for Part C; this is 7.0% of all CAPTA referrals.

4. The number who go on the Screening and Monitoring (SaM) track

- 53 of the CAPTA referrals passed the screening, but due to concerns were referred to Screening and Monitoring, this is 8.6% of all CAPTA referrals.

This table shows what status the CAPTA referrals were in on the last day of the fiscal year.

Status of FY07 CAPTA Referrals on June 30, 2007

# of Children	Percent	Status
38	6.17%	CAPTA Referral in process
9	1.46%	Referred to Part C, in referral process waiting for eligibility determination
43	6.98%	Referred to Part C and found Not Eligible
59	9.58%	Referred to Part C and found eligible and an IFSP was developed ✓
7	1.14%	Referred to Part C found eligible and parent declined Part C Services (No IFSP)
375	60.88%	Passed screening and were exited from program (No IFSP)
53	8.60%	Passed screening but due to concerns were referred to Screening and Monitoring
20	3.25%	Contact with family was unsuccessful, record closed (No IFSP)
4	0.65%	Child referred and Parent had no concerns, record closed (No IFSP)
3	0.49%	Family moved out of state, record closed (No IFSP)
1	0.16%	Child died while in foster care
2	0.32%	Late referral, referred to LEA (15 & 48 days prior to 3rd birthday)
2	0.32%	Inappropriate referral (child over the age of 3 at time of referral)
616		**TOTAL FY07 CAPTA REFERRALS**

National Survey of Children with Special Health Care Needs 2005-200... http://mchb.hrsa.gov/cshcn05/SD/nevada.htm

SNH 4

Indicator	State %	National %
CSHCN whose conditions cause financial problems for the family	23.2	18.1
CSHCN whose families spend 11 or more hours per week providing or coordinating the child's health care	11.7	9.7
CSHCN whose conditions cause family members to cut back or stop working	27.2	23.8

Core Outcomes	% of CSHCN Achieving Outcome in the State	% of CSHCN Achieving Outcome in the Nation
Families of children and youth with special health care needs partner in decision making at all levels and are satisfied with the services they receive	47.5	57.4
Children and youth with special health care needs receive coordinated ongoing comprehensive care within a medical home	41.2	47.1
Families of CSHCN have adequate private and/or public insurance to pay for the services they need	53.5	62.0
Children are screened early and continuously for special health care needs	56.3	63.8
Community-based services for children and youth with special health care needs are organized so families can use them easily	82.6	89.1
Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence	41.7	41.2

Information on this page can be found in the print version of *The National Survey of Children with Special Health Care Needs Chartbook 2005-2006*. Suggested citation: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children with Special Health Care Needs Chartbook 2005–2006*. Rockville, Maryland: U.S. Department of Health and Human Services, 2008.

S-EDMHS 1

Table 3-9 Age Group of Victims, 2006
Child Maltreatment 2006

Blank Cell	Age < 1				Age 1-3				Age 4-7				Age 8-11				Age 12-15				
State	Population	Victims	Rate	Percent	Population	Victims	Rate	Percent	Population	Victims	Rate	Percent	Population	Victims	Rate	Percent	Population	Victims	Rate	Percent	Popul
Alabama	60,926	986	16.2	11.1	178,683	1,616	9.0	18.2	242,259	1,889	7.8	21.3	242,078	1,607	6.6	18.1	256,726	2,249	8.8	25.4	13
Alaska	10,120	398	39.3	11.6	29,940	658	22.0	19.2	38,124	878	23.0	25.7	38,302	710	18.5	20.7	42,234	645	15.3	18.8	2
Arizona	98,407	527	5.4	11.8	288,966	1,053	3.6	23.6	362,386	1,128	3.1	25.2	347,246	785	2.3	17.6	353,389	744	2.1	16.6	17
Arkansas	39,844	815	20.5	9.0	115,044	1,450	12.6	16.0	150,037	2,209	14.7	24.4	149,717	1,715	11.5	18.9	155,080	2,153	13.9	23.8	8
California	555,240	10,933	19.7	12.2	1,601,758	15,665	9.8	17.5	2,033,201	19,868	9.8	22.2	2,065,423	18,246	8.8	20.4	2,187,243	18,087	8.3	20.2	1,08
Colorado	68,852	1,270	18.4	11.7	205,055	2,351	11.5	21.7	260,347	2,778	10.7	25.6	246,663	2,006	8.1	18.5	257,135	1,896	7.4	17.5	13
Connecticut	36,077	1,189	33.0	11.7	124,402	1,903	15.3	18.8	173,414	2,440	14.1	24.1	184,608	1,956	10.6	19.3	197,421	2,121	10.7	20.9	10
Delaware	11,335	210	18.5	10.9	34,284	374	10.9	19.4	43,793	518	11.8	26.8	43,444	374	8.6	19.4	46,554	335	7.2	17.3	2
District of Columbia	7,671	326	42.5	11.8	20,829	326	15.7	11.8	24,432	606	24.8	22.0	23,477	583	24.8	21.2	25,880	706	27.3	25.6	1
Florida	233,381	14,089	60.4	10.5	669,910	28,490	42.5	21.2	859,101	32,611	38.0	24.2	855,640	25,582	29.9	19.0	919,557	24,783	27.0	18.4	48
Georgia	141,488	4,522	32.0	11.4	421,388	7,741	18.4	19.4	545,359	10,005	18.3	25.1	521,052	7,831	15.0	19.7	544,614	7,586	13.9	19.1	27
Hawaii	17,529	397	22.6	19.5	52,840	359	6.8	17.7	63,775	388	6.1	19.1	62,318	347	5.6	17.1	67,614	388	5.7	19.1	3
Idaho	23,031	263	11.4	15.9	68,229	338	5.0	20.5	85,866	395	4.6	23.9	83,659	295	3.5	17.9	87,543	256	2.9	15.5	4
Illinois	176,773	3,915	22.1	14.1	534,411	6,060	11.3	21.8	700,053	6,947	9.9	25.0	701,338	5,348	7.6	19.3	730,280	4,288	5.9	15.5	37
Indiana	86,304	2,418	28.0	11.6	260,004	3,826	14.7	18.3	343,131	4,887	14.2	23.4	343,039	3,881	11.3	18.6	360,833	4,672	12.9	22.4	18
Iowa	39,179	1,674	42.7	11.5	115,368	3,552	30.8	24.3	151,031	3,808	25.2	26.1	153,366	2,628	17.1	18.0	164,402	2,196	13.4	15.1	8
Kansas	39,459	175	4.4	6.7	116,428	499	4.3	19.1	151,931	694	4.6	26.5	149,870	551	3.7	21.1	156,029	544	3.5	20.8	8
Kentucky	55,997	2,346	41.9	11.8	165,724	4,261	25.7	21.5	217,017	5,073	23.4	25.6	216,156	3,643	16.9	18.4	227,374	3,432	15.1	17.3	11
Louisiana	62,336	1,366	21.9	11.2	179,507	2,545	14.2	20.8	237,599	3,038	12.8	24.8	232,933	2,355	10.1	19.2	248,350	2,346	9.4	19.2	12
Maine	13,880	475	34.2	13.4	42,505	746	17.6	21.0	56,864	836	14.7	23.6	60,659	719	11.9	20.3	69,263	619	8.9	17.5	3
Maryland	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	Blank Cell	
Massachusetts	77,183	3,587	46.5	10.0	232,739	6,538	28.1	18.1	310,353	8,442	27.2	23.4	315,937	7,425	23.5	20.6	335,908	7,556	22.5	21.0	17
Michigan	123,873	4,077	32.9	15.0	385,127	4,851	12.6	17.9	525,820	6,008	11.4	22.1	545,967	5,142	9.4	18.9	591,095	5,433	9.2	20.0	30
Minnesota	69,394	880	12.7	11.6	209,520	1,571	7.5	20.6	266,474	1,903	7.1	25.0	270,061	1,501	5.6	19.7	288,824	1,365	4.7	17.9	15
Mississippi	43,394	621	14.3	9.9	125,196	1,056	8.4	16.9	164,876	1,579	9.6	25.2	162,613	1,271	7.8	20.3	173,371	1,352	7.8	21.6	6
Missouri	78,424	482	6.1	6.8	232,487	1,307	5.6	18.4	302,251	1,637	5.4	23.1	304,748	1,421	4.7	20.0	327,548	1,735	5.3	24.5	17
Montana	11,644	230	19.8	13.4	34,914	398	11.4	23.2	45,331	413	9.1	24.1	46,395	305	6.6	17.8	51,478	288	5.6	16.8	2
Nebraska	26,097	688	26.4	11.2	77,045	1,426	18.5	23.3	96,006	1,595	16.6	26.1	94,059	1,117	11.9	18.3	99,431	1,000	10.1	16.3	5
Nevada	37,901	964	25.4	18.0	109,948	1,177	10.7	22.0	139,565	1,282	9.2	24.0	137,617	941	6.8	17.6	140,397	764	5.4	14.3	6
New Hampshire	13,987	103	7.4	12.6	44,423	134	3.0	16.4	60,725	166	2.7	20.3	66,097	159	2.4	19.4	73,256	198	2.7	24.2	2
New Jersey	107,869	1,380	12.8	11.8	339,428	1,978	5.8	17.0	445,621	2,823	6.3	24.2	461,819	2,333	5.1	20.0	484,924	2,295	4.7	19.7	24

NU POP = 287,414
0-7 VICT = 3,423

New Mexico	28,978	731	25.2	12.8	85,085	997	11.7	17.5	110,401	1,455	13.2	25.5	108,259	1,184	10.9	20.8	115,974	1,047	9.0	18.4	5
New York	244,832	6,867	28.0	8.6	734,257	12,824	17.5	16.0	957,601	17,911	18.7	22.4	979,526	16,590	16.9	20.7	1,049,790	19,193	18.3	24.0	54
North Carolina	125,599	3,058	24.3	10.8	364,385	5,868	16.1	20.7	478,737	7,044	14.7	24.8	457,849	5,541	12.1	19.5	482,012	5,536	11.5	19.5	24
North Dakota	8,261	121	14.6	8.4	23,745	278	11.7	19.3	29,906	349	11.7	24.3	31,237	293	9.4	20.4	33,761	303	9.0	21.1	1
Ohio	146,341	4,184	28.6	10.1	442,336	7,938	17.9	19.3	593,582	10,310	17.4	25.0	605,315	7,734	12.8	18.8	647,542	8,313	12.8	20.2	33
Oklahoma	52,417	2,079	39.7	15.5	152,040	3,122	20.5	23.3	195,903	3,363	17.2	25.1	190,662	2,335	12.2	17.4	199,875	1,945	9.7	14.5	10
Oregon	45,608	1,797	39.4	13.9	138,950	2,883	20.7	22.3	185,203	3,379	18.2	26.1	187,320	2,420	12.9	18.7	195,107	1,952	10.0	15.1	10
Pennsylvania	143,912	237	1.6	5.7	436,884	409	0.9	9.9	581,789	871	1.5	21.0	608,613	867	1.4	20.9	674,097	1,296	1.9	31.3	35
Puerto Rico	49,929	945	18.9	6.5	149,555	2,280	15.2	15.6	220,338	3,868	17.6	26.4	236,767	3,380	14.3	23.1	243,441	3,229	13.3	22.1	11
Rhode Island	12,241	528	43.1	12.0	37,590	877	23.3	20.0	49,146	1,041	21.2	23.7	52,157	867	16.6	19.8	56,791	789	13.9	18.0	2
South Carolina	57,330	1,474	25.7	13.9	169,647	2,048	12.1	19.4	225,213	2,548	11.3	24.1	221,184	1,961	8.9	18.5	238,759	2,050	8.6	19.4	12
South Dakota	11,464	238	20.8	15.6	33,023	382	11.6	25.1	41,182	360	8.7	23.7	41,022	266	6.5	17.5	44,229	222	5.0	14.6	2
Tennessee	80,383	2,515	31.3	13.1	239,145	3,623	15.1	18.9	314,050	4,599	14.6	24.0	310,818	3,717	12.0	19.4	327,847	3,479	10.6	18.2	16
Texas	394,904	9,524	24.1	13.8	1,153,713	16,193	14.0	23.5	1,450,876	18,278	12.6	26.5	1,376,402	12,445	9.0	18.0	1,411,362	10,149	7.2	14.7	70
Utah	48,886	1,129	23.1	8.7	151,194	2,718	18.0	20.9	184,101	3,278	17.8	25.1	165,215	2,535	15.3	19.4	159,145	2,480	15.6	19.0	8
Vermont	6,353	53	8.3	6.2	19,952	129	6.5	15.0	26,649	213	8.0	24.8	28,944	166	5.7	19.3	32,910	210	6.4	24.4	1
Virginia	103,270	699	6.8	10.4	306,071	1,373	4.5	20.5	391,428	1,593	4.1	23.8	384,880	1,233	3.2	18.4	409,416	1,319	3.2	19.7	21
Washington	80,683	1,101	13.6	15.3	246,653	1,548	6.3	21.5	326,739	1,786	5.5	24.8	332,501	1,371	4.1	19.0	355,232	1,118	3.1	15.5	18
West Virginia	20,897	763	36.5	9.5	63,156	1,609	25.5	19.9	82,720	2,038	24.6	25.3	83,816	1,594	19.0	19.8	90,929	1,584	17.4	19.6	4
Wisconsin	69,308	705	10.2	8.3	210,508	1,380	6.6	16.2	276,786	1,854	6.7	21.8	283,109	1,537	5.4	18.1	308,401	2,275	7.4	26.7	16
Wyoming	6,797	88	12.9	11.2	20,314	212	10.4	27.0	25,579	212	8.3	27.0	25,603	131	5.1	16.7	28,273	114	4.0	14.5	1
Total	**4,105,988**	**100,142**	Blank Cell	Blank Cell	**12,194,305**	**172,940**	Blank Cell	Blank Cell	**15,844,671**	**213,194**	Blank Cell	Blank Cell	**15,837,500**	**170,944**	Blank Cell	Blank Cell	**16,768,646**	**170,635**	Blank Cell	Blank Cell	**8,60**
Rate	Blank Cell	Blank Cell	**24.4**	Blank Cell	Blank Cell	Blank Cell	**14.2**	Blank Cell	Blank Cell	Blank Cell	**13.5**	Blank Cell	Blank Cell	Blank Cell	**10.8**	Blank Cell	Blank Cell	Blank Cell	**10.2**	Blank Cell	
Percent	Blank Cell	Blank Cell	Blank Cell	**11.4**	Blank Cell	Blank Cell	Blank Cell	**19.6**	Blank Cell	Blank Cell	Blank Cell	**24.2**	Blank Cell	Blank Cell	Blank Cell	**19.4**	Blank Cell	Blank Cell	Blank Cell	**19.3**	
Number Reporting	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	

Age Group of Victims, 2006
This table breaks down the child population into age groups and lists the number of victims and rate of victimization of each age group. The first column of the table lists each State name. Information is broken out by age group for each of the following categories: population, number of victims, rate, and percentage. The age groups are less than 1 year, 1-3, 4-7, 8-11, 12-15, and 16-17. The youngest children had the highest rate of victimization of 24.4 per 1,000 children younger than 1 year.

Return to Chapter 3

Return to Chapter 3: Figures and Tables

S-EDMHS=

Embargoed Until May 17
Prekindergarten Expulsion 8

Table 4. ***Expulsion Rates for Prekindergarten and K-12 by State***

State	PreK Expulsions/1,000	PreK SE_M	K-12 Expulsions/1,000	PreK / K-12 Ratio	PreK Teachers Expelling %	PreK Teachers Expelling SE_P
1. New Mexico	21.10	1.61	1.48	14.22	20.00	1.03
2. Maine	14.73	3.10	0.68	21.50	17.79	2.82
3. Alabama	14.12	3.45	1.03	13.70	12.50	2.93
4. Delaware	13.04	3.34	1.47	8.90	11.54	3.58
5. North Carolina	13.04	3.57	1.90	6.86	14.71	3.11
6. Tennessee	12.54	2.76	3.79	3.30	20.69	3.91
7. Connecticut	12.31	2.62	1.18	10.40	15.52	2.51
8. Missouri	12.02	2.97	0.70	17.22	20.00	3.85
9. Massachusetts	11.15	2.82	0.80	13.93	15.56	2.84
10. Virginia	10.25	2.74	1.49	6.88	11.59	3.01
11. Nevada	9.48	2.11	2.28	4.16	9.09	1.03
12. New York	9.11	2.48	0.47	19.18	11.72	2.27
13. Washington	8.73	2.13	3.71	2.36	9.72	2.70
14. Georgia	8.58	2.43	1.76	4.88	13.89	3.40
15. Vermont	8.32	2.01	1.00	8.31	4.65	1.68
16. California	7.49	2.01	2.52	2.97	12.11	2.26
17. Hawaii	7.39	2.04	0.00	--	14.63	3.24
18. Wisconsin	7.34	1.84	1.43	5.12	12.08	2.30
19. Florida	6.64	2.03	0.37	18.04	12.99	3.24
20. Oregon	6.17	2.08	3.51	1.76	10.94	2.89
21. New Jersey	6.16	2.26	0.38	16.15	7.85	1.92
22. Oklahoma	6.12	1.84	2.15	2.84	10.41	2.07
23. Texas	5.99	1.87	2.93	2.04	10.71	3.05
24. Maryland	5.97	1.97	0.97	6.18	8.20	2.72
25. Alaska	5.86	1.78	2.12	2.77	6.38	2.17
26. Colorado	5.17	1.71	2.62	1.97	8.54	2.75
27. Arizona	4.79	1.46	1.61	2.98	6.94	2.23
28. Ohio	4.76	1.76	4.17	1.14	8.38	1.87
29. Arkansas	4.40	1.54	1.20	3.66	7.02	2.35
30. Nebraska	4.15	0.00	1.90	2.18	7.69	0.00
31. Louisiana	3.58	1.53	7.78	0.46	6.56	2.52
32. West Virginia	3.58	1.39	1.43	2.51	3.17	1.45
33. Pennsylvania	3.54	1.39	1.06	3.33	4.88	1.97
34. Minnesota	3.41	1.39	0.76	4.51	4.83	1.45
35. Illinois	2.70	1.32	0.96	2.81	6.58	2.20
36. Michigan	2.36	1.30	1.67	1.41	4.11	1.97
37. Iowa	2.32	1.20	0.43	5.45	1.92	1.32
38. Kansas	2.13	1.24	1.80	1.19	3.51	1.82
39. South Carolina	2.04	1.08	7.16	0.28	2.78	1.60
40. Kentucky	0.00	0.00	1.21	0.00	0.00	0.00
Idaho	No PreK		1.18	NA	No PreK	
Indiana	No PreK		7.93	NA	No PreK	
Mississippi	No PreK		3.20	NA	No PreK	
Montana	No PreK		1.10	NA	No PreK	
New Hampshire	No PreK		0.72	NA	No PreK	
North Dakota	No PreK		0.56	NA	No PreK	
Rhode Island	No PreK		2.14	NA	No PreK	
South Dakota	No PreK		1.09	NA	No PreK	
Utah	No PreK		3.43	NA	No PreK	
Wyoming	No PreK		1.46	NA	No PreK	
NATION	**6.67**	**0.53**	**2.09**	**3.20**	**10.39**	**0.76**

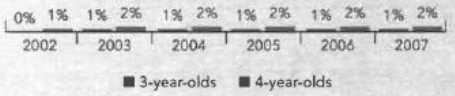
Note. Expulsion rates indicate the number of students expelled per 1,000 students enrolled. States are tabled in descending order, based on prekindergarten expulsion rates. "PreK / K-12 Ratio" indicates the degree to which the PreK expulsion rate surpasses the K-12 expulsion rate (e.g., in New Mexico, the preK expulsion rate is 14.22 greater than the K-12 expulsion rate). PreK national data are weighted by a factor of *N/n*. PreK/K-12 Ratios were determined based on extended precision calculations, and may differ somewhat from division with numbers rounded to nearest hundredth, as they are presented in this table.

ECEM 2

Nevada

2007

PERCENT OF STATE POPULATION ENROLLED



STATE SPENDING PER CHILD ENROLLED (2007 DOLLARS)

Nevada's Early Childhood Education Comprehensive Plan (ECE) began in 2002, providing funds to start new center-based prekindergarten programs and expand programs that already existed. Beginning in 2003, quality standards from the ECE program were also applied to the Classroom on Wheels (COW) initiative, through which buses refurbished as preschool classrooms make stops at sites across the state. COW had started as a grassroots effort and later began receiving state funding. In 2005, a guaranteed set-aside with funding for COW was eliminated, and COW programs were required to compete for funding along with ECE programs. Although the COW model continues to exist, it is no longer a distinct initiative, as COW was absorbed into the ECE program as one of its components effective with the 2006-2007 school year.

The state controls the quality of the ECE program primarily through the requirements of a competitive grant process rather than through explicit program policy. Competitive grants are available to public schools, Head Start centers, private agencies, faith-based centers, and family child care homes. Subcontracting with other agencies is allowed for programs using the COW model. Though ECE primarily serves 3- and 4-year-olds, children become eligible for the program at birth. Eligibility criteria are determined by individual grantees, but programs must identify needs in their communities. Typically the grantees define the need for services on the basis of low-income or English Language Learner status.

Starting with the 2007-2008 school year, the name of Nevada's state-funded preschool initiative changed from the Early Childhood Education Comprehensive Plan to the Nevada Pre-Kindergarten Education Program. Also, the age range for children in the program narrowed to children from ages 3 to 5.

ACCESS RANKINGS	
4-YEAR-OLDS	3-YEAR-OLDS
36	26

RESOURCES RANKINGS	
STATE SPENDING	ALL REPORTED SPENDING
23*	28

* In previous Yearbooks, only state spending was ranked.

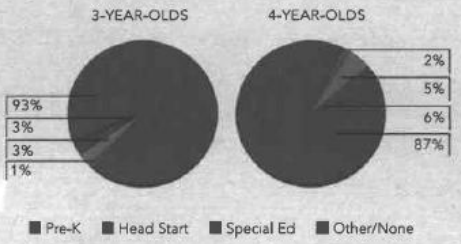
NEVADA EARLY CHILDHOOD EDUCATION COMPREHENSIVE PLAN

ACCESS

Total state program enrollment	949
School districts that offer state program	71%
Income requirement	None [1]
Hours of operation	Determined locally [2]
Operating schedule	Academic year
Special education enrollment	3,131
Federally funded Head Start enrollment	2,834
State-funded Head Start enrollment	0

ECE 949
School Dist PK 2,690
Head Start 2,834
6,473

STATE PRE-K AND HEAD START ENROLLMENT AS PERCENTAGE OF TOTAL POPULATION



QUALITY STANDARDS CHECKLIST

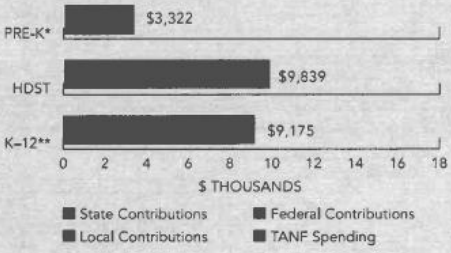
POLICY	STATE PRE-K REQUIREMENT	BENCHMARK	DOES REQUIREMENT MEET BENCHMARK?
Early learning standards	Comprehensive	Comprehensive	☑
Teacher degree	BA [3]	BA	☑
Teacher specialized training	ECE license (36 units in ECE) [3,4]	Specializing in pre-K	☑
Assistant teacher degree	HSD	CDA or equivalent	☐
Teacher in-service	5 credit hours/5 years	At least 15 hours/year	☑
Maximum class size		20 or lower	☑
3-year-olds	16		
4-year-olds	20		
Staff-child ratio		1:10 or better	☑
3-year-olds	1:8		
4-year-olds	1:10		
Screening/referral and support services	Support services only [5]	Vision, hearing, health; and at least 1 support service	☐
Meals	None	At least 1/day	☐
Monitoring	Site visits and other monitoring	Site visits	☑

TOTAL BENCHMARKS MET: 7

RESOURCES

Total state pre-K spending	$3,152,479
Local match required?	No
State spending per child enrolled	$3,322
All reported spending per child enrolled*	$3,322

SPENDING PER CHILD ENROLLED



* Pre-K programs may receive additional funds from federal or local sources that are not included in this figure.

** K-12 expenditures include capital spending as well as current operating expenditures.

Data are for the '06–'07 school year, unless otherwise noted.

[1] Although there is no income requirement, all programs must indicate that there is a need for pre-K services in their communities. Typically, programs define the need in their communities by low-income or ELL status.

[2] Most programs operate 2.5-3 hours per day, 4 or 5 days per week. Programs must operate at least 10 hours per week.

[3] COW teachers already employed as of 2003-2004 were grandfathered in and do not have to meet current teacher training requirements, but are expected to work toward meeting them.

[4] The requirement for specialized training may be met with a Birth-Kindergarten license or a Birth-Grade 2 license.

[5] Screening and referral requirements are decided at the local level. Support services include parenting support or training and parent involvement activities that typically encompass parent conferences.

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National Association for the Education of Young Children

NAEYC Academy for Early Childhood Program Accreditation

NAEYC-Accredited Program Search Result

Programs - to review, correct, or update your program information contact the Academy at accreditation.information@naeyc.org or (800) 424-2460 and select 3. This website is updated on the 5th of every month.

Search Results 5/28/2008 12:55:42 PM Total Records: 27

CCSN Campus Child Care Cheyenne **Valid Until: 07/31/2010**
3200 East Cheyenne Avenue C1P
North Las Vegas, NV 89030
County: Clark
Phone: 702 651-4944
Program ID Number: 591735
Email: tracy.lewis@csn.edu
Website:

CCSN Campus Child Care-Charleston **Valid Until: 11/30/2010**
6375 West Charleston Boulevard WCH
Las Vegas, NV 89146
County: Clark
Phone: 702 651-7390
Program ID Number: 583033
Email: julie.dockter@csn.edu
Website: http://www.ccsn.edu

CCSN Early Childhood Education Lab School **Valid Until: 11/30/2009**
3200 East Cheyenne Avenue S1B
North Las Vegas, NV 89030
County: Clark
Phone: 702 651-4004
Program ID Number: 289812
Email: janis.fikes@csn.edu
Website:

Child and Family Research Center **Valid Until: 05/31/2008**
Sarah Fleischmann Building # 030 University of Neveda Reno
Reno, NV 89557
County: Washoe
Phone: 775 784-6762
Program ID Number: 275950
Email: swaugh@unr.edu
Website: http://hhs.unr.edu/cfrc/

Child and Family Research Center **Valid Until: 05/31/2008**
38 W. 11th Street
Reno, NV 89557
County: Washoe
Phone: 775 784-4533
Program ID Number: 275950
Email: swaugh@unr.edu
Website: http://hhs.unr.edu/cfrc/

Children's Choice Learning Center at Boulder — **Valid Until: 04/30/2010**
4185 Vegas Valley Drive
Las Vegas, NV 89121
County: Clark
Phone: 702 431-0907
Program ID Number: 590878
Email: rosalind.brown.valenti@childrenschoice.com
Website:

Children's Choice Learning Center at MGM Grand — **Valid Until: 03/31/2009**
3799 Las Vegas Boulevard @MGM
Las Vegas, NV 89109
County: Clark
Phone: 702 597-9925
Program ID Number: 589999
Email: monica.sparta@childrenschoice.com
Website: http://childrenschoice.com

Children's Choice Learning Centers at Palace — **Valid Until: 04/30/2010**
2750 South Rancho Drive
Las Vegas, NV 89102
County: Clark
Phone: 702 365-0113
Program ID Number: 590874
Email: rickie.ryan@childrenschoice.com
Website:

Children's Choice Learning Centers-Sunset — **Valid Until: 07/31/2011**
1310 West Warm Springs Road
Henderson, NV 89014
County: Clark
Phone: 702 898-0963
Program ID Number: 590876
Email: lienise.martinez@childrenchoice.com
Website: http://www.childrenschoice.com

Children's World — **Valid Until: 11/30/2009**
3570 North Buffalo Drive Ave.
Las Vegas, NV 89115
County: Clark
Phone: 702 655-6565
Program ID Number: 560057
Email: cduran@klcorp.com
Website:

Back ***Next***

Programs - to review, correct, or update your program information click here.
This website is updated monthly.

Learn more about NAEYC Accreditation.

For those who need help selecting a program, NAEYC provides resources to help you choose a quality child care program.

View our Summary of accredited programs.

Read news about NAEYC-accredited programs.

ECEM 1, 3, 6, 8

www.unr.edu/hcs/hdfs/eva_essa%5Cchildcareworkforcestudy.pdf

THE NEVADA CHILD CARE WORK FORCE STUDY

WHO CARES FOR NEVADA'S CHILDREN?

A Profile of the Demographic, Economic, and Quality Aspects of Child Care in Nevada

Eva L. Essa, Ph.D.
Principal Investigator

ECEM 1

CHAPTER 8

THE QUALITY OF NEVADA'S CHILD CARE

Quality is a key element in child care because of its relationship to children's development. The observational component of the Nevada Child Care Work Force Study provides insight into the quality of programs and how that quality is related to the development of young children. In more than 100 child care center classes across the state, the classroom environment and the teacher were observed and children were tested. The findings from these observations are very similar to those of numerous other studies,[1] that there is a clear relationship between the quality of care and children's language, cognitive, and social competence. Specifics of the results are discussed below, in this chapter. In addition, information from the various questionnaires also provides some insight into aspects of child care that are associated with quality.

MEASURE OF CHILD CARE QUALITY AMONG NEVADA CHILD CARE CENTERS

In 103 classrooms, trained research assistants spent about three hours observing and rating the classroom environment to determine child care quality. Quality of the classroom environment was examined with a measure called the *Early Childhood Environments Rating Scale* (ECERS).[2] It is the most widely used scale of its kind, and has been used in numerous research studies. It is also used as an evaluation tool for child care program self-improvement. The ECERS includes seven sub-scales

and a total of 49 items, each of which is rated on a 7-point scale. The final score yields a number, between 1 and 7, which is used an indicator of quality. A score of 1 to 3 denotes poor quality, 3 to 5 medium quality, and 5 to 7 excellent quality.

Ratings for the 103 Nevada classrooms observed for this study are shown in Figure 8.1. The average ECERS score among Nevada programs was 4.7, which falls within the medium range. Overall, 19% of centers received poor scores, between 1 and 3; 41% were given scores between 3 and 5, in the medium range; and 40% were rated between 5 and 7, receiving high scores. This distribution of Nevada scores can be compared to the findings of the national *Cost, Quality, and Child Outcomes Study*[3], which are shown in previous chapter (Figure 7.4). In comparison, Nevada has fewer programs in the medium range and more in the high and low areas.

It should be cautioned, however, that the Nevada scores may not accurately represent all classrooms in the state. Although every effort was made to enlist programs that would have a wide range of quality, several factors may have hindered such an effort. For one thing, many programs that were contacted chose not to be observed; we do not know whether the programs that declined to participate have a different level of quality than those that did participate. In addition, fewer programs from Las Vegas chose to take part in the study, although every effort was made to have an accurate geographic representation; this geographic imbalance may also have contributed to an inaccurate representation of Nevada's child care quality. One factor that may have resulted in a larger proportion of classrooms with higher scores is that directors were asked to specify the classroom or classrooms in which observations were to take place and, undoubtedly, directors identified their most experienced and skillful teachers. Finally, 103 is a relatively small number of classrooms on which to base valid conclusions; if we had been able to include a larger sample, it may be that the results would have different shown a different distribution of levels of quality in child care programs.

THE QUALITY OF NEVADA'S CHILD CARE

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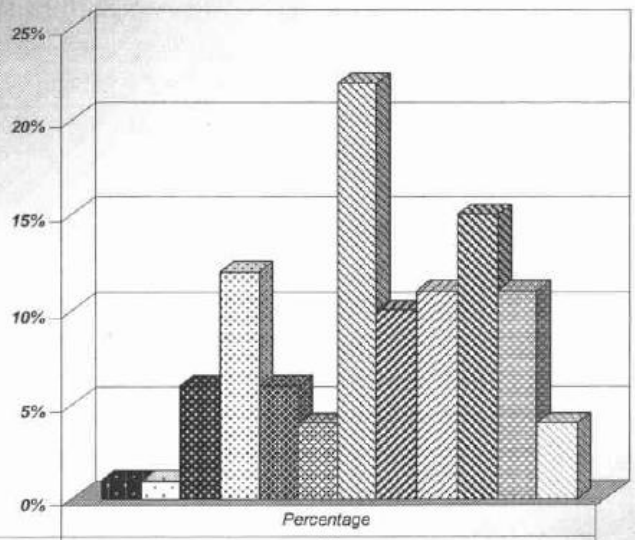
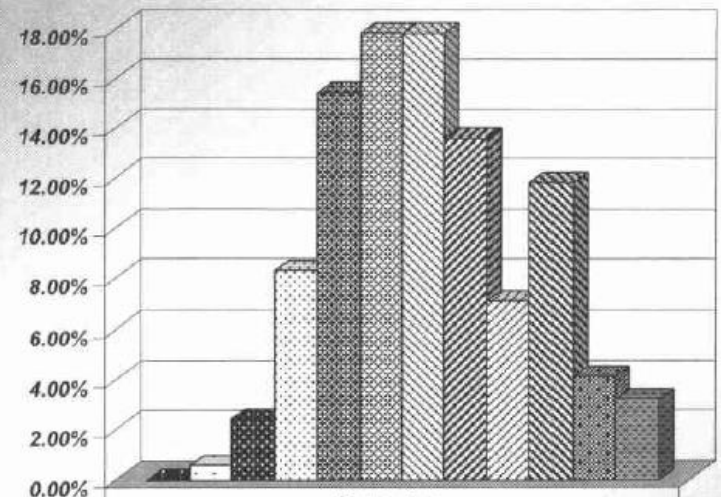
Figure 8-1. Distribution of Nevada child care programs by scores received on the ECERS (Early Childhood Environments Rating Scale)



	Percentage
1.0 to 1.5 (Low)	1%
1.5 to 2.0 (Low)	1%
2.0 to 2.5 (Low)	6%
2.5 to 3.0 (Low)	12%
3.0 to 3.5 (Medium)	6%
3.5 to 4.0 (Medium)	4%
4.0 to 4.5 (Medium)	22%
4.5 to 5.0 (Medium)	10%
5.0 to 5.5 (High)	11%
5.5 to 6.0 (High)	15%
6.0 to 6.5 (High)	11%
6.5 to 7.0 (High)	4%

Figure 7-4. Ratings of child care center quality, using the Early Childhood Environments Rating Scale in the Cost, Quality, and Child Outcomes in Child Care Study



	Percentage
1.0-1.5	0.00%
1.5-2.0	0.60%
2.0-2.5	2.40%
2.5-3.0	8.30%
3.0-3.5	15.40%
3.5-4.0	17.80%
4.0-4.5	17.80%
4.5-5.0	13.60%
5.0-5.5	7.10%
5.5-6.0	11.80%

These same points were repeated when the licensing surveyors were asked their views about the adequacy and stringency of licensing regulations. More than three-fourths of the respondents felt that requirements for caregiver education and training and ratio and group size clearly need to be more stringent in Nevada's regulations. Some of the licensing staff were more specific in their responses, indicating that ratios should be computed by child care classroom rather than by the facility as a whole. On the other hand, about a third of the regulators felt that licensing regulations were appropriate, although a number felt that there were too many ambiguous or "gray" areas in the standards.

ECEM 3

parents were asked about issues related to child care when their children were ill, nearly half indicated that finding care for their children when they were ill posed a difficulty for them.

Weekend, night, and evening care. Ten percent of Nevada child care centers and 9% of licensed homes are available to care for children during weekends. By contrast, one-third of non-licensed homes provide weekend care. A small minority of centers report being open for night and evening care. Only 14 centers (4%) indicate that they are open up to 18 hours a day, and two of those note that they are open 24 hours.

SUBSIDIES FOR THE COST OF CARE

Some families receive subsidies for the care of their children, primarily through funds provided as part of the Welfare Reform Act. A substantial number of programs indicate that some of the families whose children are in their programs receive such financial aid. Sixty-eight percent of centers, 29% of licensed homes, and 73% of non-licensed homes reported having at least one family receiving a child care subsidy. The majority of both centers and homes have only one child whose cost of care is subsidized, but one-third of centers and licensed homes and 10% of non-licensed homes indicate that they serve more than one such child. From information provided by the directors who responded to the study and answered this question, 3,377 children receive subsidized care. According to information from responding family home care providers, the care for 231 children in such programs is subsidized. The majority of the 159 non-licensed family home providers surveyed for this study take care of children whose families receive subsidies, since their names were derived from subsidy lists, although, apparently, some no longer care for children whose care is subsidized.

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Directors and family child care providers were also asked how long, on average, it takes to receive subsidy reimbursements and approximately how much, in time and other expenses, it costs the program to process subsidy paperwork per child. Just under two-thirds of directors and licensed family caregivers indicate that reimbursements are received in 30 days or less, while the remainder noted that it takes between 31 and 90 days to receive reimbursements. In relation to the cost of processing paper work, 64% of directors and 82% of home care providers estimated

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CHAPTER 2

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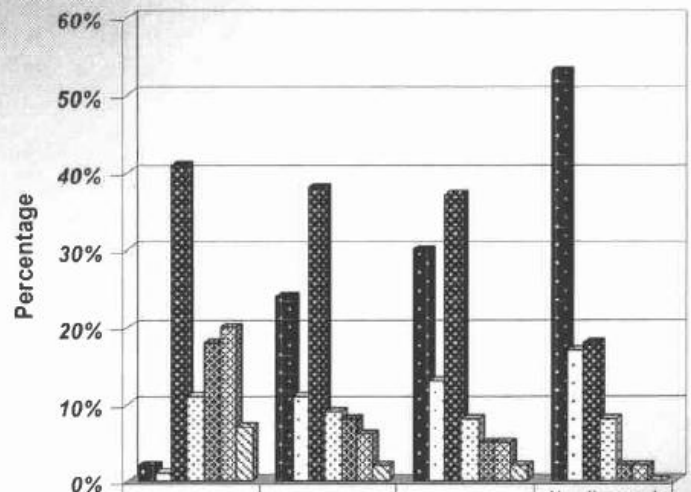
Education: Directors have the highest level of education among the groups included in this study, with 62% having a college degree (two-year, four-year, or graduate degree) in any field. Among teachers, 28% have earned some type of college degree, while 20% of licensed home care providers and 10% of non-licensed home care providers have degrees. If only four-year and graduate degrees are considered, this would include 40% of directors,15% of teachers, 9% of licensed and 5% of non-licensed home caregivers have earned such degrees. Many individuals in all four groups, however, have enrolled in some college courses. Compared to national statistics, Nevada's child care work force generally includes fewer individuals with college degrees but more individuals who have taken at least some college-level course work.[4]

Figure 2-4. Early Childhood Education Background of Nevada Child Care Providers



	Directors	Teachers	Licensed Home Care Providers	Non-licensed Home Care Providers
none or no answer provided	2%	24%	30%	53%
high school child development courses	1%	11%	13%	17%
some college-level early childhood courses	41%	38%	37%	18%
one-year certificate in early childhood education	11%	9%	8%	8%
associate degree in early childhood education	18%	8%	5%	2%
bachelor degree in early childhood education	20%	6%	5%	2%
graduate degree in early childhood education	7%	2%	2%	0%

ECEM-8

for young children. In many programs children are expected to sit and attend quietly for protracted periods of time, an activity that is not natural or appropriate for preschoolers and, according to research, often not conducive to learning.[11]

ACCREDITATION OF NEVADA CHILD CARE PROGRAMS

One indicator of child care quality is program accreditation by a professional early childhood education organization. Accreditation is, in fact, viewed as one strategy for improving overall child care quality in a state or area.[12] The most widely used accreditation system is that of the National Association for the Education of Young Children (NAEYC).[13] The stated purpose of NAEYC's accreditation is "to improve the quality of care and education provided for young children in group programs in the United States." The process involved in attaining NAEYC accreditation is lengthy and intensive. A program has to engage in an extensive self-study, based on the *Accreditation Criteria for High Quality Early Childhood Programs*.[14] This step is followed by a site visit by a team of trained volunteer validators, who undertake an in-depth examination of every aspect of the program. Finally, all materials are reviewed by a three-member national commission, composed of experts in early care and education, who judge if the program is in compliance with the criteria and, if it is, grant accreditation status for three years.

In mid-2002, there were 12 Nevada programs accredited by NAEYC. This is a low number, representing about 3% of Nevada's child care centers. It is also low when compared to other states. Only two states, North Dakota and South Dakota, have fewer accredited programs than does Nevada. NAEYC estimates that approximately 1,700 children are served in these 12 programs. That figure represents approximately 5% of children cared for in Nevada child care facilities.[15]

These figures do not present the entire picture, however. NAEYC reports that two Nevada programs are in the process of re-accreditation while 24 others are in the initial stages of the accreditation process. This move toward getting more accredited programs in the state has been facilitated by a Nevada program, funded through federal flow-through Child Care Quality Enhancement monies, that was initiated in early 2002. Four Child Development Specialists – two in Las Vegas, one in Reno, and one in Elko – and an additional part-time consultant in Reno, are available to assist Nevada child care programs that are interested in becoming accredited by NAEYC.

Currently, they are working with 36 centers across the state, including 20 in Reno, 8 in Las Vegas, and 8 in the northeastern part of the state. Their consultation helps these programs in the self-assessment step of the process, assists them in identifying areas that need improvement so they can reach accreditation standards, and provides resources for making needed changes. In addition, 13 licensed family child care homes in the Reno area are receiving help toward attaining accreditation by the National Association for Family Child Care.

Accreditation, especially with the support of these Child Development Specialists, has recently also been tied to another aspect of Nevada child care. In May, 2002, the state Child Care Advisory Board approved a formula for tiered reimbursement for child care centers and licensed homes that receive reimbursement for families eligible for subsidy support. The tiered reimbursement schedule allows for differential rates of funding, depending on the program's quality rating. The highest rating, along with the highest reimbursement, will go to programs that have achieved accreditation. This approach was instated as an incentive for child care centers and licensed homes to strive for higher levels of quality.